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LOYOLA UNIVERSITY CHICAGO

THE CONNECTION BETWEEN CHILDHOOD SEXUAL ABUSE
AND EATING DISORDERS IN WOMEN:
A REVIEW OF THE LITERATURE

A THESIS SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
MASTER OF ARTS
DEPARTMENT OF COUNSELING PSYCHOLOGY

BY
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CHICAGO, ILLINOIS

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CHAPTER I

INTRODUCTION

In the mid-1980s clinicians began to note the high incidence of histories of child sexual abuse (CSA) in women and eating disorders in female clients. As one reviews the most commonly noted long term effects of CSA and the common symptoms of eating disorders, the similarities are marked. Clinicians and researchers have begun to explore the possible connection between childhood sexual abuse and eating disorders in women. Each year, the body of literature grows as the research tries to narrow the connection and better understand the relationship between these two psychological phenomena. The following review of literature may serve as a resource for others to learn about the investigation into the connection of childhood sexual abuse and eating disorders in women. In addition, a model of the relationship is proposed to suggest future research possibilities. Since this thesis focuses on eating disorders and sexual abuse in women, the female pronoun will be utilized throughout this paper to describe the people with eating disorders and experiences of childhood sexual abuse.

The literature on this connection has its problems, yet

it is moving toward building a theory about this relationship. It is the author's hope that this body of literature soon leads to sound treatment models and recommended standard questions about abuse history and eating patterns for all people entering therapy or psychiatric hospitals. In addition, the author hopes this review of the literature, its criticisms of existing studies and ideas for further study, encourages more sound research so as to better understand women's real life experiences.

CHAPTER II

EATING DISORDERS

This section reviews the major concepts related to eating disorders. First, the characteristics and prevalence rates of three major eating disorders (anorexia nervosa, bulimia, and compulsive overeating) are presented. Next, the major theories related to the etiology of eating disorders are reviewed, including organic, addiction, psychoanalytic, family, developmental, and feminist theories. The eating disorder literature reviewed in this chapter consists of a mixture of qualitative and quantitative research, as well as theories based on clinical experiences. Finally, a critique of the theories and research on eating disorders is presented.

Prevalence and Characteristics of Eating Disorders in the General Population

People with eating disorders share an obsession with food, but they do not use food in the same way. Some eat a great deal and become obese, some abstain and starve themselves, others binge eat and get rid of the food immediately by vomiting, laxatives or excessive exercise (Atchley & Heeger, 1984). At the core of disordered eating

are identity conflicts, low self-esteem, powerlessness, lack of self-acceptance and anger (Root, 1990). Eating disorders are a defense, protecting sufferers from chaotic fears and feelings (Atchley & Heeger, 1984). Eating disorders lie on a continuum, with anorexia and obesity at the two poles and bulimia lying in between (Russell, 1985; Wooley & Wooley, 1980). The core psychological themes reflected in disordered eating are the pursuit of identity, power, specialness, validation, self-esteem, and respect (Root, 1990). Bulimia and anorexia nervosa are two eating disorders found primarily among young, white, affluent women in modern, industrialized countries (Bruch, 1973; Crisp, Palmer & Kalucy, 1976; Garner & Garfinkel, 1980; Levenkron, 1982). Most females who develop anorexia and/or bulimia do so by age 25, usually beginning sometime in the teenage years (Kennedy & Garfinkel, 1985; Root, 1983). However, individuals within every racial/ethnic group and within every socioeconomic level are susceptible to developing eating disorders. Several researchers suggest that eating disorders are becoming increasingly common in all American racial/ethnic minorities (Hsu, 1987; Pumariega, Edwards & Mitchell, 1984; Root, 1990; Silber, 1986) and socioeconomic levels (Levenkron, 1982; Root, 1983). Obesity, on the other hand, is six times more prevalent among low socioeconomic women (Vogel, 1985).

Ninety to 95% of anorexic and bulimics are female

(Chernin, 1981; Garner & Garfinkel, 1980). Five to 20% of college women report bulimic behavior (Ordman & Kirschenbaum, 1986; Pyle, Halvarson, Neuman & Mitchell, 1986). It has been estimated that one in 95 females aged 16 and over will become anorexic (Orbach, 1978; Russell, 1970). Twenty-six percent of adults are compulsive overeaters, with more women than men (Hoyenga & Hoyenga, 1982; Orbach, 1978). The above statistics suggest that females exhibit eating disorders more commonly than males. However, further research investigating males and eating disorders is warranted.

In conclusion, Boskind-White (1983) estimated that one in eight women suffer from some form of an eating disorder. Eating disturbances of many types are very common with women and girls in western nations. There is still a need to investigate eating disorders to come to better understand these females and their problems. This greater understanding will aid clinicians in their diagnosis and treatment of women with eating disturbances.

Characteristics of Anorexia Nervosa

Anorexia nervosa is an eating disorder characterized by one's refusal to maintain a minimally normal body weight, an intense fear of gaining weight, and a significant disturbance in a person's perception of the shape or size of her body (APA, 1994). Anorexics have a fear of getting fat

that does not abate even as they lose weight. Their body image becomes distorted, they appear gaunt and starved, and deny that anything is wrong (Atchley & Heeger, 1984). This purposeful starvation may occur alone or in combination with excessive exercising, occasional binge eating, vomiting, and/or laxative abuse (Taub & McLorg, 1989). Anorexia is also characterized by a weight loss of at least 25% of original body weight, a distorted attitude toward food or weight that overrides hunger and reassurance, a failure to recognize nutritional needs, and an enjoyment of losing weight and refusing food. Anorexics also have a desired body image of extreme thinness, exhibit unusual hoarding or handling of food, and may experience episodes of bulimia (Feighner, Robbins & Guze, 1972). No medical illness or other psychiatric disorder accounts for the weight loss of anorexic females. Other characteristics of females with anorexia include amenorrhea (cessation of menstruation), lanugo (fine, downy body hair), bradycardia (pulse rate under 60), and periods of over-activity (Feighner, et al., 1972).

Some themes running through the psychology of anorexic women are self-hatred, low self-esteem, and little self-respect. The anorexic's inner world is chaotic, full of horror and anxiety. The anorexic establishes a frantic concern over her body and bodily functions in her drive for thinness and attempts to gain control over herself and

improve her self-esteem (Bruch, 1978). Anorexics also experience feelings of extreme isolation and loneliness, and struggle toward producing a differentiated identity. They have little idea of their own needs and wants, but are committed to pleasing others. Anorexics tend towards over-achievement, yet feel a deep sense of helplessness or ineffectiveness in spite of outward appearance of being in total control (Bruch, 1973; 1978; 1982; Szekely, 1989).

Characteristics of Bulimia

Bulimia is an eating disorder characterized by repeated episodes of binge eating followed by inappropriate compensatory behaviors such as self-induced vomiting, misuse of laxatives, diuretics or other medications; fasting; or excessive exercise, as well as a disturbance in one's perception of body shape and weight (APA, 1994). Bulimics feel out of control and highly anxious when they binge, they recognize that their bingeing is abnormal, which results in self-criticism, secretiveness, and feelings of guilt, shame and depression (APA, 1980; Atchley & Heeger, 1984; Fairburn & Cooper, 1982; Mitchell & Pyle, 1982; Root & Fallon, 1986). Most bulimics' weight is usually normal or close to normal and they appear functionally well (Taub & McLorg, 1989). However, they have an obsession and preoccupation with food, weight, and appearance (Root & Fallon, 1986).

Bulimics can be characterized by dissociation of self

from the body, repression of painful material, gaps in memory, denial of problems, and foggy recollection of childhood (Root, Fallon & Friedrich, 1986). They have difficulty labeling feelings and frequently numb themselves from feeling anger, fear, anxiety, and depression (Root & Fallon, 1986; Root & Friedrich, 1989; Weiss & Ebert, 1983). Bulimics have a low self-esteem, a poorly defined sense of self, and a sense of powerlessness (Root & Fallon, 1986). Consequently, they have great difficulty trusting others and fear intimacy and abandonment, which leads to social withdrawal and isolation (Fallon & Root, 1986; Root & Friedrich, 1989; Weiss & Ebert, 1983). In addition, some bulimics use their eating disorder to serve a specific function. Binging and purging enable bulimics to repress and dissociate from their feelings and their past traumas. It allows them to focus exclusively on their food, weight, eating, vomiting and subsequent feelings of self-hatred, disgust and relief (Root & Fallon, 1989).

Characteristics of Compulsive Overeating/Binge-Eating

Compulsive overeating or binge-eating is characterized by eating, in a discrete period of time, an amount of food that is definitely larger than most people would eat during a similar period of time, as well as a sense of lack of control over eating during the episode (APA, 1994). Individuals with this eating pattern seen in clinical

settings have varying degrees of obesity (APA, 1994).

Compulsive overeaters often eat in the absence of physical hunger and feel guilty after overeating (Orbach, 1978).

Compulsive overeaters are preoccupied with thoughts of food, diet and body size, and experience a discrepancy between public and private eating habits (Orbach, 1978). This obsession with food carries with it enormous amounts of self-loathing and shame (Orbach, 1978). The experience of overeating or bingeing is often described by the people who do it as operating in a state of mind where their conscious or rational self is not choosing or guiding their actions (Millman, 1980). According to Orbach (1978), compulsive overeating is linked to a desire to get fat and become obese. The desire that many women have for getting fat can be understood by exploring how the fat has served the women. Orbach (1978) found that being obese meant a variety of things to the women with whom she worked. Some women believed that the fat desexualizes the female body so as to provide sexual protection. In addition, the women believed that their obesity helped establish boundaries, exert control over their life circumstances, and provide strength (Orbach, 1978).

One function of compulsive overeating may be to dull feelings with which people have difficulty coping. The compulsive overeating provides a way for the energy usually expended on worrying to be focused on a person's concern for

her body size (Orbach, 1978). Through compulsive overeating, females swallow their feelings that are too dangerous to confront and therefore, anesthetize their negative emotions. The compulsive overeater's unmet needs and negative emotions are covered with a layer of fat so that these feelings won't get expressed (Millman, 1980; Orbach, 1978). Compulsive overeating provides an insulated world where all negative feelings are harnessed to complaints and self-loathing about body size and eating habits (Orbach, 1978). Fat is a symbol of everything she dislikes in herself, a manifestation of the horridness she feels inside (Orbach, 1978).

Causal Explanations

Eating disorders may be explained as a complex interaction of many different factors over time. Such factors include the sociocultural environment, the family environment, biochemical factors, and the intrapsychic condition of an individual (Bruch, 1973; Garfinkel & Garner, 1982; Johnson, Lewis, & Hagman, 1984; Striegel-Moore, Silberstein & Rodin, 1986). This section will discuss the theories of the etiology of eating disorders.

Organic Explanations

Many causal factors explored within the eating disorder literature are organically based. Some of the organic

research studied the endorphin levels in anorexic and bulimic patients because endorphins mediate the pattern of restricting eating or overeating. Other research focused on a possible genetic cause for the intense craving some eating disordered people have for carbohydrates (Atchley & Heeger, 1984). Vandereycken and Meermann (1984) reported that abnormal neurotransmitter regulation causes anorexia.

Some studies have concluded that eating disorders are physiologically multi-determined and a multifactorial etiology should be sought (Krahn, Morley, & Levine, 1987; Morley & Blundell, 1988). Decisions of food intake seem to occur at cortical levels, while the control of appetite occurs at the hypothalamus and brain stem levels, and involves duodenal hormone activity, gastrointestinal peptides and gastric wall distension (Krahn, et al., 1987; Morley & Blundell, 1988). Orbach (1978) and Gordon (1990) reviewed research exploring the effects that lesions on the hypothalamus may have on appetite excitation or suppression. Bemis (1987) reported that some findings point to a possible hypothalamic disorder which causes the endocrine abnormalities in anorexic females.

A few theories have been developed to try to explain organic factors for obesity. The fat cell theory traces adult obesity back to obesity in childhood, which is accompanied by an increase in the number of fat cells in the body. The number of fat cells can never be decreased, even

by dieting later in life, thus leading to a higher likelihood for obesity in adulthood (Hirsch & Knittle, 1970). A biochemical theory attributes obesity to a different type of gene that obese people have from average weight people (Bruch, 1973; Orbach, 1978). The different genes result in different enzymes which are involved in chemical reactions related to fat storage in the body. Another theory reviewed by Orbach (1978), the insulin related theory, attributes compulsive overeating to hyperinsulinism. The presence of excess insulin induces insensitivity to insulin and thus, stimulates the person to eat more so as to maintain a balance.

Psychological Addiction

Another possible explanation for the development of eating disorders is that eating disorders are addictive behaviors. It has been hypothesized that dieting, bingeing and purging set up a physiological response that requires automatic repetition of the behaviors (Casper, et al., 1980; Halmi, Falk, & Schwartz, 1981). The bulimic experience, for example, can be viewed as a fluctuating cycle of moods that corresponds to the binge purge behavior (Johnson & Larson, 1982). Feeling out of control and anxious prior to the binge is followed by the binge, in which those feelings increase and feelings of guilt and anger emerge. In order to relieve the anxiety and anger, and regain some sense of

control, the person purges (Johnson & Larson, 1982). However, even after the purging and the completion of the cycle, the bulimic still feels guilt and other negative emotions (Beumont & Touyz, 1987). In an effort to maintain some sort of regular mood state, the person may turn to a habitual and addictive pattern of eating.

Psychoanalytic

During the first half of this century, the prominent assumption was that anorexia and psychosexual development were connected by women's fear of assuming the adult, biologically determined female role (Pizzolo, 1989). One explanation given for anorexia proposed by Sigmund Freud was that self-starvation was related to unresolved issues of adult sexuality (Freud, 1888/1966). Anorexia was viewed as a form of conversion hysteria that symbolically expressed repudiation of sexuality, specifically of oral impregnation fantasies (Bruch, 1985; Freud, 1958). To deny sexual feelings, the anorexic must make herself prepubescent again by starving (Atchley & Heeger, 1984). Orbach (1978) summarized the psychoanalytic explanation of female obesity as a symptom of an unresolved oedipal complex related to problems of separation-individuation, narcissism and insufficient ego development.

Family

Bruch (1973) helped shape a more contemporary view of eating disorders exploring the anorexics' relationship with food and family. She identified anorexics who are obsessed with food and controlling their appetites as using self-starvation as a reactionary protest to parental constraints and expectations in an attempt to establish some degree of independence and control (Bruch, 1978; Taub & McLorg, 1989). Atchley and Heeger (1984) described the control over food as an attempt to gain control of their unstable family environment. Bulimics, who also experience an overwhelming feeling of lack of control of their environment, control their bodies in a desperate attempt to gain some sense of control of their environment (Root & Fallon, 1989).

Families characterized by enmeshment or disengagement may create environments in which females do not feel they have mastery over or control of their lives (Johnson & Flach, 1985; Kagan & Squires, 1985; Minuchin, Rosman, & Baker, 1978; Strober & Humphrey, 1987; Waller, Slade, & Calam, 1990). In enmeshed families, boundaries between members' roles are blurred and autonomous behavior is discouraged. The intrusiveness of such families does not provide privacy or psychological and physical space for members and leaves them feeling powerless (Herman, 1981; Root & Fallon, 1986). An eating disorder functions as a defining behavior and an attempt at autonomous self control

by an adolescent (Humphrey, 1989; Taub & McLorg, 1989). For example, bulimia is something that is hidden and private for a girl in an intrusive family environment. The eating disorder allows the individual a private world that is not shared with anyone. The binge-purge ritual provides a reliable and predictable experience in a chaotic world (Root & Fallon, 1989). In a disengaged family, the family may be held together by focusing on the eating disorder (Minuchin, et al., 1978). The lack of control that females feel in such family environments can result in a sense of ineffectiveness and low self-esteem, which may lead females to restrict food or purge food as a means of asserting control in their own lives (Johnson, et al., 1984).

Dysfunctional communication and relationship patterns are present in the families of people with eating disorders (Root & Fallon, 1986; Taub & McLorg, 1989). In bulimic families, for example, there is often a multi-generational history of parent child coalitions (Root & Fallon, 1986). Humphrey and Stern (1988) hypothesized that there is multi-generational, family-wide emotional deprivation and a failure of basic nurturance within bulimic families. The mother is described as overcontrolling of the child's emotions, rejecting, and withholding of her affection. The father is described as undercontrolling with his impulses and emotions. In addition, he uses his relationship with his daughter to gratify his own needs, often at the expense

of his daughter's needs (Humphrey & Stern, 1988). The daughters are encouraged to be passive, helpless, and other-oriented (Brodsky & Hare-Mustin, 1980).

Also, eating disorder families have difficulty resolving and coping with intense feelings (Minuchin, et al., 1978; Taub & McLorg, 1989). Often, the child is used to maintain a balance in the family system, at the expense of her individual development. Other research reports negative interactions between the eating disorder females with their fathers and conflictual spousal relationships as common among eating disorder families (Minuchin, et al., 1978; Vogel, 1985). Thus, food may be used to fulfill the emotional hunger that was never satisfied within the family (Humphrey & Stern, 1988). Eating disorders may develop as females try to control a chaotic environment and fill an emotional emptiness that they feel inside.

Developmental

Bruch (1985) and Orbach (1985) attributed eating disorders to underlying disturbances in the development of the personality. These personality deficits include disturbances in self-identity and autonomy. Due to the developmental disturbances, an insecurity towards oneself likely emerges. This internal insecurity becomes easily transposed into an insecurity of one's body. Absence of consistent appropriate responses to an infant's needs,

especially the need of food, deprives a child of the essential groundwork for bodily identity. Therefore, a child grows up unable to differentiate between biological cues versus emotional cues. In addition, a child is unable to differentiate biological and emotional cues from interpersonal experiences (Bruch, 1985). The experience of inconsistent need fulfillment may lead a child to develop an inadequate sense of self (Friedman, 1985; Orbach, 1986). In puberty, anorexics feel helpless under the impact of new, unpredictable bodily urges and, therefore, overcontrol their needs, which leads to self-starvation (Bruch, 1985; Orbach, 1985).

According to Orbach (1985), the psychological requirements of successful femininity for the adult woman in American society includes three demands: she must defer to others, she must anticipate and meet the needs of others, and she must seek self-definition through connection with another. The consequence of these demands are that by denying themselves, women are unable to develop an authentic sense of their needs and a feeling of entitlement for their desires. Many of the aspects of the self are underdeveloped, producing insecurity and an unstable sense of self (Orbach, 1985).

The role of the mother includes directing her daughter in gender appropriate ways and, therefore, the mother unconsciously instills social laws into her daughter

(Orbach, 1985). Females who develop eating disorders may not be encouraged to be independent or to express their feelings or needs. As a result, they may only be able to identify a narrow range of emotions and may doubt their self-worth and value. Thus, their ability to make decisions and become autonomous may be impaired (Bruch, 1985). They may feel helpless and ineffective in conducting their own lives. Their severe discipline over their bodies may represent a desperate effort to ward off panic about being completely powerless (Bruch, 1985).

Chernin (1981) viewed anorexia as a way for adolescent girls to cope with the lives they cannot control. At the time of adolescence, many anorexics are not prepared for the mastery of the challenges with which they are confronted at this developmental stage, such as autonomy, individuation, and sexual maturity (Attie & Brooks-Gunn, 1989; Chernin, 1981; Striegel-Moore, et al., 1986). For a girl achieving a new sense of self, which involves the integration of accelerating physical growth and a new body shape, may be more difficult than for a boy (Tobin-Richards, Boxer, & Petersen, 1983). Adolescence is a period in which the convergence of physical and psychosocial changes demands an adaptive response from the maturing girl. In refusing food, the anorexic seeks to slow down sexual maturation and postpones mastery of the normal developmental stage of adolescence (Brumberg, 1988; Taub & McLorg, 1989).

Feminist

In developing countries, fatness is a symbol of wealth. In modern, industrialized nations, fatness no longer signifies affluence because people generally have an adequate supply of food. Thus, thinness has come to symbolize discretionary eating (Taub & McLorg, 1989). In the last few decades, thinness has become the body ideal that most American women pursue.

A new interpretation of eating disorders has evolved. The fear and rejection expressed by female anorexics is not fear of becoming an adult or a teenager, but of becoming a woman (Pizzolo, 1989). Eating disorders in females may be a reaction to the cultural, political, and economic constraints imposed on women in America. Many research findings support that there is a broad range of cultural forces that devalue women and promote negative feelings in young females that may lead to eating disturbances (Chernin, 1981; Silverstein, Perdue, Wolf, & Pizzolo, 1988; Szekely, 1989).

According to Chernin (1981; 1985) and Orbach (1986), anorexia is a failed female protest centered on the female body that brings tragic consequences to the anorexics. "Feeling powerless, confusion and fear,... they attempt to gain control over their shapes and physical needs. They felt power in their ability to ignore their hunger" (Orbach, 1978, p. 167). Yet, these frail anorexics only increase

their sense of ineffectiveness in that they fit the feminine image of a delicate, thin, and dependent female (Orbach, 1978; Taub & McLorg, 1989). "The quest for thinness is a kind of caricature, a self-mockery of the experience of being a woman, since it dramatically demonstrates the physical discomfort, self-denial and self-sacrifice required in the conventional female role" (Millman, 1980, p. 121). Chernin (1981) stressed that the protests that these women express through agonizing physical form are not to be considered conscious protests. Such a conclusion would overestimate the control anorexics have over their emaciation and would underestimate anorexia as a psychological disorder.

Compulsive overeating and obesity may also be viewed as rooted in the social inequality of females. Obesity may be an attempt to break free of society's sex role stereotypes and culturally defined experiences of females (Orbach, 1978). Traditionally, in American culture, males can demonstrate their success through achievement in work, whereas it is mainly through what females do with their appearance that they are able to exhibit their mastery and achievement to others and themselves (Millman, 1980).

The traditional sex role stereotypes, which frame women as objects of beauty and service to others, may lead to feelings of inferiority, incompetence, low self-esteem and confused sense of identity in females (Kutcher, 1988).

The emphasis on presentation as the central aspect of a female's existence makes her extremely self-conscious. Females are continually manipulated by the media images of proper womanhood, which almost exclusively presents women in a sexual or family context. The current emphasis is on thin women with a youthful prepubescent look as being the most admirable in our culture (Striegel-Moore, et al., 1986). Femininity is equated with the adjectives of fragile, thin, small, helpless, and delicate (Root & Fallon, 1986). Fairytales promise women success, happiness, and love if they are beautiful, kind, passive, and self-sacrificing (Kohlenschlag, 1979). These images are extremely powerful because they are presented as the only reality for females and females are urged to conform or risk being an outcast (Millman, 1980; Orbach, 1978). Also, these images may give females the false hope that their power rests in their beauty and kindness (Root & Fallon, 1986; Szekely, 1989). Women may eventually realize that passivity and self sacrifice are not reinforced with an equal distribution of rights or power. Rather, they may realize that many women are objectified, devalued and kept subordinate (Kutcher, 1988; Millman, 1980; Vogel, 1985). Women are taught to see themselves from the outside and learn that women's bodies are not their own and are not satisfactory as they are, but they must conform to the ideal physical type, which is defined and controlled by others (Miller, 1986; Millman,

1980; Orbach, 1978; Szekely, 1989). These images may give the message that as a female, a person will never be loved, wanted, respected or admired unless she changes herself, and this process inevitably involves pain (Millman, 1980). This model of femininity is experienced by females as unreal, frightening, and unattainable. Yet, the overwhelming cultural message is that thin is beautiful and beautiful is good, and thus, everything will fall into place for women if they are thin (Orbach, 1978; Striegel-Moore, et al., 1986). Many women have been sacrificing their well-being and attention to personal needs in their pursuit of approval for being feminine (Root & Fallon, 1986).

Because these images are the only socially acceptable models of feminine behavior, concern for body size is a constant preoccupation for females (Millman, 1980; Orbach, 1978). It has become the norm for women to diet and to be dissatisfied with their bodies (Root, 1990; Root & Fallon, 1986). The relentless pursuit of thinness may signify women's striving to have a sense of worth and control in situations that are experienced as ruled by others (Szekely, 1989). Even a woman's situation of defining herself as a healthy and acceptable person is ruled by societal stereotypes and presented to women through many cultural mediums, such as the media. This current image of women in our culture is linked to the development of eating disorders in females (Faust, 1983; Striegel-Moore, et al., 1986). In

the climate of our culture, anorexia nervosa is bred because females compare their bodies to these media images, which oppose health and strength (Millman, 1980).

Fat expresses rebellion against powerlessness of females, the pressure to look and act a certain way, and being evaluated on a certain image (Bruch, 1973; Chernin, 1981; Kaplan, 1980; Orbach, 1986). Obesity and compulsive overeating may symbolize a relinquishing of control for some or the asserting of control for others in a world that allows females little sense of effectiveness or autonomy (Millman, 1980). Instead of a life which can feel out of control, everything is transferred to a body that can be governed (Bloom, 1987; Chapkis, 1986). A female with an eating disorder feels in control by forcing her body to do something that will put things back in order, stabilize her, and bring her relief (Bloom, 1987).

Society demands women to nurture others rather than themselves (Brown, 1985; Millman, 1980). Females are expected to devote much of their energy to the lives of others, putting other people's needs ahead of their own. To be a female is to live with the tension of giving and not getting (Orbach, 1978). Eating becomes the one thing that females can do to replenish themselves when they are drained by their efforts to perform in the traditional female role (Millman, 1980). Eating becomes a displacement of their unfulfilled need for love (Millman, 1980). As a result,

compulsive overeaters eat to try to fill the void they feel inside. Females also are discouraged from expressing their anger and are taught to accept what they are given without any complaints. Females, therefore, may try not to show their anger or feel it themselves. Instead, their anger is directed inward and their bodies may become the objects of the hatred that they cannot directly express (Root & Fallon, 1986; 1989). Fat provides space and protection for feelings (Orbach, 1978).

Limits of Explanations

The problem with the etiological theories reviewed in this chapter is that they attempt to reduce the eating disorders to a single explanatory term of pathology, such as a vulnerable personality, boundary disturbances or an inadequate composition of traits (Szekely, 1989). These processes are conceptualized as if they originated within the individual or within the interactions between isolated individuals. They seem to treat the individual's biology, psychology, family and society as separate factors. In order to understand the development and prevalence of eating disorders in females, the perspective that human development occurs within a sociocultural process needs to be more closely examined (Szekely, 1989). In addition, the social explanation of eating disorders neglects the biological and addictive aspects of eating disorders. None of the theories

reviewed in this chapter, when viewed alone, seem to completely explain the etiology of eating disorders. It seems that these theories need to be looked at together to get a more complete understanding of the etiology of eating disorders in women. The potential interactions of biology, individual psychological development, family, society, and addiction need to be more closely examined to better understand the etiology of eating disorders in women.

Limits of Research

The imperfect research methods utilized in the development of these explanations needs to be taken into consideration. Some of these methodological limitations include sampling bias, self selection bias, nonstandardized measures, operational definitions and control problems. "In the study of eating disorders, methodology is guided by the stereotypes that white middle to upper class girls and women develop eating disorders" (Root, 1990, p. 531). The settings in which many eating disorder studies occur may bias the sample. Much research on eating disorders is conducted at specialty clinics, universities, and private practices in which the majority of the therapists and clients are white and upper-middle to upper class. Also, much of the research on eating disorders uses The Diagnostic and Statistical Manual, 3rd edition-revised (DSM-III-R) (APA, 1987) diagnostic criteria for anorexia and bulimia as

a guideline for discussing and evaluating eating disorders in people. The DSM-III-R criteria, however, are derived from observing and studying, almost exclusively, white samples (Root, 1990). Looking at race, ethnicity and social class as independent variables could begin to shed some light on the pervasiveness of eating disorders in American society. Also, outreach by researchers and therapists into minority and lower socioeconomic communities may be a good way to begin to understand the similarities and differences among the diverse racial and ethnic groups which collectively constitute American society. "We need to include diversity of American racial/ethnic groups so that our discussions and theories of disordered eating have validity beyond the white, middle-class, female stereotype" (Root, 1990, p. 534).

Also, many problems with the research methods make it difficult to compare studies or develop a solid theoretical basis for understanding eating disorders. The various research studies do not use a standard definition for eating disorders and, therefore the results of different studies cannot easily be compared or integrated to build a solid interpretation of eating disorders. Some studies define eating disorders as only including those cases fitting into DSM-III-R diagnostic guidelines for anorexia and bulimia, while others define eating disorders as running the continuum from anorexia to compulsive overeating and

obesity. Another problem lies in the multitude of measures used to study eating disorders. Many studies include nonstandardized interviews and questionnaires, which limits the generalizability of the findings. The samples of many of the studies are limited to inpatient or outpatient populations, thus the selection bias of the study sample does not allow findings to be generalized to the general populations. As mentioned earlier, almost all of the samples are composed of white, educated, middle to upper class females, which again limits generalizability. Some of the studies did not have control groups with which to compare the results of the identified eating disorder population. Finally, only a few studies controlled for confounding variables, such as age, other illness or other psychological problems.

Though there are problems with many of the studies on eating disordered women, the multitude and variety of research on eating disorders in women gives way to the development of a number of theories of the etiology of various eating disorders. People in various professions and people who adhere to various schools of thought support different theories as the most viable explanation for understanding eating disorders in women. In addition, it seems likely that a number of clinicians find some value in at least of a few of the theories reviewed in this chapter.

CHAPTER III

CHILDHOOD SEXUAL ABUSE

This section reviews the major concepts of childhood sexual abuse with a focus on sexual abuse that occurs within the family. First, the characteristics and prevalence rates of childhood sexual abuse of females are presented. Next, the major theories of sexual abuse are reviewed. This review emphasizes the feminist theories on childhood sexual abuse. The sexual abuse literature reviewed in this chapter consists of a mixture of qualitative and quantitative research, as well as theories based on clinical experiences.

Incidence and Characteristics of Childhood Sexual Abuse in the General Population

Since the late 1970s, childhood sexual abuse has entered the public spotlight. The feminist movement has greatly contributed to the development of a new awareness about the reality of sexual abuse (Herman, 1981; Russell, 1986). Sexual abuse has emerged as the major form of child abuse in the United States (Finkelhor, 1979). However, sexual abuse has failed to become a sustained public issue because it is still extremely difficult for people to discuss openly many sexual topics. Sexual abuse is not

easily defined or identified and still often goes unreported (Jones, Jenstrom, & MacFarlane, 1980).

There is not one generally accepted definition of sexual abuse. Childhood sexual abuse has been defined as contacts or interactions between a child and adult, or between a child and an older child, when the child is being used as an object of gratification for power or sexual desires (Jones, Jenstrom, & MacFarlane, 1980; Pizzolo, 1989). The inability for the child to give informed consent to the sexual involvement is implicit in this definition (Benward & Densen-Gerber, 1975). Experiences of sexual abuse include exhibitionism, voyeurism, verbal sexual advances, pornographic photography, fondling of genitals and breasts, oral-genital contact, digital penetration, and vaginal or anal intercourse (Bass & Davis, 1988; Driver & Droisen, 1989; Finkelhor, 1980; Russell, 1986). Childhood sexual abuse has also been defined as exposure of a child to sexual stimulation that is inappropriate for the child's age, level of psychosexual development and role in the family or society (Luther & Price, 1980). The offender shows disregard for the child's developmental and emotional needs (Kempe & Kempe, 1984).

Children most vulnerable to sexual abuse are in the prepubescent and preadolescent period of ages eight through twelve (Finkelhor, 1979; 1986). However, sexually abused children range in age from infancy to young adulthood

(DeFrancis, 1969). Ninety percent of sexual abuse survivors are female. (Finkelhor, 1979; 1984; Gelinas, 1983).

Childhood sexual abuse has been cited as occurring in 19% to 62% of the female population (Finkelhor, 1979; Russell, 1983; Wyatt, 1985). Due to different sampling methods, definitions of sexual abuse, questions asked to research participants, and under-reporting by survivors of sexual abuse, the prevalence of sexual abuse is believed to be far greater than any statistics indicate (Finkelhor, 1984). Ninety five percent to 98% of sexual abuse offenders of females are reportedly male (Finkelhor, 1984; Gelinas, 1983). Childhood sexual abuse crosses all racial, religious, educational and socioeconomic lines (Cleveland, 1986; Driver & Droisen, 1989). It occurs in families, institutions, classrooms and on the street (Driver & Droisen, 1989). In addition, childhood sexual abuse is experienced by males. The study of childhood sexual abuse of males is an area of study which is necessary, but severely neglected and, thus, warrants further research.

Most survivors of childhood sexual abuse never tell anyone about the abuse at the time (Herman, 1981). Children may keep the abuse a secret because they fear rejection, blame, punishment, abandonment, family disruption, and not being believed (Finkelhor, 1980; Jones, Jenstrom, & MacFarlane, 1980). Also, feelings of low self-esteem, fear, hopelessness, depression, and responsibility hold the child

back from disclosing the sexual abuse (Maltz & Holman, 1987). Families who do find out about the abuse are reluctant to report it because of social taboos, fears of blame or punishment, feelings of guilt, or protection of the perpetrator (Cleveland, 1986; Jones, Jenstrom, & MacFarlane, 1980). Also, survivors may repress the abusive experiences as a way to cope with the pain of sexual abuse.

As more people investigate childhood sexual abuse, it is being discovered that childhood sexual abuse is not what it was once thought to be. Sexual abuse of children has been thought to be an isolated incident instigated by a stranger. It is now known that a large proportion of sexual abuse occurs within the child's family or intimate social network and it is not uncommon for the abuse to go on for an extended period of time (Finkelhor, 1979; 1984; Jones, Jenstrom, & MacFarlane, 1980; Russell, 1986). Social scientists are only now beginning to understand the scope of the problem of childhood sexual abuse and to identify its calamitous effects (Pizzolo, 1989).

Short Term Effects

Children who are sexually abused experience a variety of feelings, as a result of the abuse, and may portray certain characteristics which have come to be commonly seen among sexual abuse survivors. Many of these short term effects fall within the characteristics of Posttraumatic

Stress Disorder (APA, 1994). They may feel shock, anxiety, fear, guilt, shame, confusion, violation, a sense of being dirty, and a sense of abandonment and betrayal (Browne & Finkelhor, 1986; Cleveland, 1986; DeFrancis, 1969; Leaman, 1980; Maltz & Holman, 1987). Children who experience sexual abuse may also feel humiliation, anger, degradation, depression, helplessness, powerlessness, a sense of self-blame, and a sense of being out of control (Browne & Finkelhor, 1986; Finkelhor, 1979; Gelinas, 1983; Leaman, 1980; Summit, 1983). Some children no longer feel safe where they live, have an aversion to going home, and may run away. Sexually abused children also experience loss of their self-esteem, develop a poor self-image, withdraw and become isolated (Browne & Finkelhor, 1986; Cleveland, 1986; DeFrancis, 1969; Leaman, 1980; Maltz & Holman, 1987). Also, children may eat less, experience a sudden weight change, changes in their sleeping, nightmares, and develop psychosomatic complaints. These children may cope with the abuse by acting out through changing their school performance, participating in delinquent behavior, displaying inappropriate sexual behavior, being sexually promiscuous, abusing alcohol or drugs, practicing self-mutilation, attempting suicide, selectively restructuring reality, or by developing dissociative identity disorder (Cleveland, 1986; Maltz & Holman, 1987; Summit, 1983).

Generally, it is not the physical or sexual experience

that is so traumatic to girls who are sexually abused. Rather, the psychological aspects have a greater effect because children perceive that they are in danger because they are in the hands of someone who is not meeting their needs in the expected manner (Finkelhor, 1979). Children are likely to become extremely confused when a known and trusted adult demands that they participate in activities that make them feel uncomfortable or seem wrong (Leaman, 1980). Sexually abused children are expected to meet the needs of their perpetrators at the expense of their own and learn that others do not really care to respond to their inner concerns (Lindberg & Distad, 1985). While sexually abused children become adept at sensing how others are thinking and feeling, they may learn to discount and invalidate their own needs. Children who get the message that what they feel and want does not count will come to feel that they are not lovable and not deserving of care by others (Maltz & Holman, 1987). These children may come to incorrectly believe that any misery they experience is their own fault (Maltz & Holman, 1987).

Often, the survivors' perceptions are discredited and denied by the offenders and others, which may lead the survivors to doubt their own perceptions of reality (Maltz & Holman, 1987). Survivors of sexual abuse grow up without a sense of protection and security. They often do not trust the adults in their lives (Maltz & Holman, 1987). Also,

these children feel a tremendous stress and sense of isolation as they sustain the secret of the abuse and maintain an "emotional shield" against conflict and injury (Lindberg & Distad, 1985). The sexually abused children continually struggle with their positions in the relationships with the abusers and attempt to gain some control over their feelings of helplessness and victimization (Summit, 1983). Sexual abuse leaves children with a sense of self-doubt and limited ability to trust themselves, which, over time, fosters emotional and social isolation, as well as self-hatred (Maltz & Holman, 1987; Summit, 1983).

Survivors may come to feel that they have no worth except as a sexual object and may confuse the distinction between sex and love or affection (Cleveland, 1986). The feelings that girls may have about going through puberty and being a female may also be affected by their experiences of sexual abuse. Reaching puberty may be a fearful experience and survivors may reject their female identity because the sexual abuse disrupts the process of self acceptance which is so important to the development of a positive self-esteem (Maltz & Holman, 1987).

Long Term Effects

Several studies have reported that women that were abused as children suffer from long-term effects years after

the abuse occurred. Russell (1986), and Maltz and Holman (1987), through their direct dialogue with female survivors of childhood sexual abuse, found that women felt increased levels of depression, anxiety, sadness, guilt, shame, fear, anger, confusion, hopelessness, powerlessness, helplessness and a sense of being different from others. Impaired self-esteem, negative self-concept, identity confusion, self-hatred and self-blame were also experienced by many women who were sexually abused as children (Finkelhor, 1984; Herman, 1981; Maltz & Holman, 1987; Russell, 1986). Russell (1986) also reported that the sexual abuse survivors she interviewed had increased negative feelings and attitudes about their bodies and about men in general.

According to Maltz and Holman (1987), the pervasive and intense feelings that sexual abuse survivors experience are often manifested in self-destructive behaviors, such as eating disorders, drug and alcohol abuse, delinquent behavior, prostitution, sexual promiscuity, suicide attempts and abusing other people (Browne & Finkelhor, 1986; Gelinas, 1983; Goodwin, 1989; Maltz & Holman, 1987; McNaron & Morgan, 1982). The development of an eating disorder that results in extreme thinness or in an overweight condition, for example, can be an unconscious reaction to the sexual abuse and a way of avoiding sexual maturity or appearing sexually attractive. While eating disorders and other self-destructive behaviors are intended to serve a protective

function for the adult survivor, these behaviors only reinforce feelings of social isolation, rejection and inadequacy (Maltz & Holman, 1987).

Feeling such intense negative emotions has also been reported to cause other problems for survivors of sexual abuse. One such problem is the establishment and maintenance of intimate interpersonal relationships and healthy sexual relationships (Herman, 1981; Maltz & Holman, 1987; Sgroi, Blick & Porter, 1982). The level of mistrust and betrayal that survivors feel toward the abusers and other adults makes it difficult for them to be emotionally intimate with other people (Russell, 1986). Also, survivors have a difficult time expressing their feelings or knowing what they need, which are essential elements to a healthy relationship (Herman, 1981). According to Russell (1986), female survivors' experiences of childhood sexual abuse negatively impacted their sexual feelings and perception of their sexuality as adults. Many survivors are unable to enjoy sex and may avoid or have a compulsive desire for sexual relationships (Browne & Finkelhor, 1986). Also, female survivors of childhood sexual abuse are prone to being revictimized in sexually or physically abusive relationships (Finkelhor, 1979; Maltz & Holman, 1987; Russell, 1986).

There are a multitude of psychological disorders survivors can manifest and a variety of coping mechanisms

survivors utilize, including posttraumatic stress disorder characteristics such as sleeping problems, nightmares, and flashbacks of the abuse. The research done by Finkelhor (1987), and Lindberg and Distad (1985) conclude that women sexually abused as children often have a need to control and be perfectionistic as ways of coping with their feelings and abusive experiences. Survivors often utilize denial and repression so as to bear the intensity of their feelings and the reality of their experiences (Bass & Davis, 1988).

Female survivors of sexual abuse may also manifest psychological disorders, such as borderline personalities, dissociative identity disorder, dissociative symptoms, anxiety disorders and antisocial behavior at a higher rate than the general population (Bass & Davis, 1988; Browne & Finkelhor, 1986; Summit, 1983).

Causal Explanations

Psychoanalytic

Freud's original theory of childhood sexuality could have potentially brought the subject of childhood sexual abuse into scientific discussion. Childhood sexual experience played a key role in Freud's early theories of neurosis (Finkelhor, 1979). At first, he suggested that childhood sexual trauma was at the root of adult psychological problems. Freud later changed his mind and decided that the stories he heard from female patients about

sexual abuse by male relatives were fantasies (Finkelhor, 1979). Freud discounted the experiences of incest victims and shifted responsibility onto the children through his hypothesis about the development of the Oedipus Complex (Russell, 1986). Freud concluded that incestuous fantasies, rather than overt incestuous acts, were critically important in personality development and at the root of neuroses (Cleveland, 1986). Accordingly, psychopathology stemmed from the child's failure to resolve the Oedipal situation (Finkelhor, 1979). The firm establishment of the fantasy model led Freud and other psychoanalysts to discount their patients reports of childhood sexual abuse (Cleveland, 1986). Freud's revised theory created an ideology of denial and blaming the victim, which has been one of the biggest obstacles to the serious study and promotion of the problem of childhood sexual abuse (Finkelhor, 1979).

Family Systems

Families in which sexual abuse occurs tend to be closed and lacking emotional connection to people outside of the family (Maltz & Holman, 1987). The world outside of the family is perceived with great suspicion and the family members are taught that the outside world is evil and dangerous, and outsiders are not to be trusted. As a result, the family tends to isolate itself and limits the members' relationships with peers (Sauer, 1982). The family

has tight external boundaries and very loose internal boundaries (Brassard & McNeill, 1987; DeYoung, 1982). Sexually abusive families meet all of their needs within the family unit (Brassard & McNeill, 1987; DeYoung, 1982). Enmeshment occurs with a loss of boundaries between family members in which the unique individuality of members merge or blend together into a general mix of selves. This lack of differentiation is such that when a family member attempts to separate, it is considered an act of betrayal (Sauer, 1982). Members of enmeshed families are emotionally overinvolved, and experience a lack of privacy and respect among themselves (Kutcher, 1988).

Sexual abuse within a family occurs as a result of long standing family disorganization (Cleveland, 1986). Frequently, both parents have suffered from severe early deprivation themselves, which may compromise their ability to parent maturely (Wells, 1981). The marriage is often dissatisfying due to the limited communication and emotional closeness between the parents (Maltz & Holman, 1987). Role reversals between mother and daughter may occur due to an altered family structure (Kempe & Kempe, 1984; Sauer, 1982).

The sexual abuse literature often studies the father as the perpetrator and lacks the study of other family members and non-family members as perpetrators of sexual abuse. In this review, when the word "father" is used, the reader should interpret as including other trusted males in the

survivor's family. Families in which sexual abuse occurs tend to be patriarchal with the father demanding submission from the family members (DeYoung, 1982). In families where a hierarchy of power exists, those with more power and control do as they please with members who have less authority (Sauer, 1982). Often, the father has more power to demand that his needs be met. In such families, female family members are seen as being responsible for meeting the needs of the male family members (Maltz & Holman, 1987). A father can justify having sexual relations with a child within this sex role belief system (Maltz & Holman, 1987).

The sexual abuse within the family often develops in the context of the father's emotional needs, the mother's depletion, and the daughter's parentification (Gelinas, 1983). In abusive families, fathers may seek to attain a feeling of power either by exerting themselves as head of a household in a forceful or authoritarian way, or may act helpless and needy so that the children feel they must take care of their fathers. The fathers may try to meet their emotional and sexual needs through sexually abusing their children (Maltz & Holman, 1987). Mothers may have a weakened capacity to be responsive to others and convey this deficit to their children. In turn, the parents may turn to a daughter to take over some of the parental responsibilities (Gelinas, 1983). Numerous adult responsibilities may decrease the amount of care and

nurturance the parentified child receives (Driver & Droisen, 1989; Finkelhor, 1979; Maltz & Holman, 1987). A parentified child performs parental task functions, has internalized responsibilities for these functions, builds her identity around caretaking, and meets the emotional needs of the family to the exclusion of her own (Gelinas, 1983).

The parentified child's needs are sacrificed for whatever the parents see as their own greater needs (Cleveland, 1986; Jones, Jenstrom, & MacFarlane, 1980). The child's basic sense of self-worth can be associated with her ability to second guess the needs of others in her family. There is little emphasis on autonomy and self-direction and, therefore, it is difficult for that child to develop a positive self-image (Kutcher, 1988). Often, family members in such family systems, especially the parentified child, develop low self-esteem and come to believe that they are not worthy of care (Kutcher, 1988).

In conclusion, social norms and institutions are seen by some theorists as playing a critical role in the family system and resulting family dynamics (Driver & Droisen, 1989; Herman, 1981). These theorists believe that the prospect of independent survival of a mother and her children is made to seem quite impractical by society. Rather than risk desertion of the man she is extremely dependent upon and subservient to, a mother may capitulate to her husband and maintain the sexual abuse secret (Herman,

1981). Mothers and daughters who maintain the sexual abuse secret may do so because they feel powerless under the power of the father (Driver & Droisen, 1989). The power distribution is so unequal that one persecutes, one is victimized, and a third remains a helpless bystander (Driver & Droisen, 1989). More research needs to be conducted on perpetrators of abuse other than male authority figures, including female abusers and sibling abuse, and how different perpetrators effect the impact of the abuse on survivors.

Social

In order to get a full understanding of the problem, it is important to examine sexual abuse of children within the context of gender and generational inequalities (Russell, 1986). In contemporary society, men as a class continue to dominate women as a class (Driver & Droisen, 1989). There is a powerlessness of children as a class of people who are treated as possessions of adults, especially in their families (Driver & Droisen, 1989). Some of the causal factors that are theorized to contribute to the occurrence of sexual abuse include the way that men are socialized to behave sexually and the power structure in which they act out this sexuality (Russell, 1986). In addition, societal myths about childhood sexual abuse, such as blaming the child or disbelief of the child, are suggested to contribute

to the occurrence of sexual abuse (Driver & Droisen, 1989).

Our society socializes men to be sexually exploitative and women to be sexually victimized (Maltz & Holman, 1987; Russell, 1986). Since men make the rules and enforce them, they also assume the right to violate them (Finkelhor, 1979). Sex role stereotyping may lead potential abusers to believe that within the context of the family, women and children are the property of men (Maltz & Holman, 1987). Having the power, both in the society and in the family, men can maintain a double standard and rationalize sexual abuse (Finkelhor, 1979). In a system of sexual and generational inequality, female children lack the resources to defend themselves against sexual victimization (Finkelhor, 1979).

Child sexual abuse represents a misuse of structural power that society legitimately accords to males and adults (Driver & Droisen, 1989). As this power exists, there also exists the potential for every man to misuse his power over women, and for every adult to misuse power over children through sexual abuse. By failing to provide deterrents, society says "yes" to the misuse of male and adult power (Driver & Droisen, 1989). The prevailing legal, medical and psychiatric atmosphere in this country currently and during the past century has been seen by some people as denying the practice of sexual abuse and protecting abusers. Such an attitude, on an individual and social level, creates a sociocultural environment that is dangerous for women and

children (Rush, 1977; Pizzolo, 1989).

Limits of Research

The different methods of inquiry and definitions of sexual abuse used in the various studies of CSA need to be taken into consideration when reviewing the sexual abuse literature. There is no consensus among researchers and practitioners about what sex acts constitute sexual abuse, what age defines a child and who qualifies as a perpetrator (Russell, 1983). Thus, the outcomes of various studies have different meanings.

In addition, there is a chance of underreporting in CSA research due to many factors, including repression of CSA, shame, and lack of trust with researchers. Given the underreporting, another problem with this body of research arises, which is the lack of true comparison groups of nonabused women. Also, the diversity of subjects is not clearly stated in many studies.

CHAPTER IV
THE CONNECTION BETWEEN CHILDHOOD SEXUAL ABUSE
AND EATING DISORDERS

Many clinicians and some researchers, in the last ten years, have begun to investigate what the relationship between CSA and eating disorders really looks like, or if it exists at all. This section reviews the most significant research which examines the connection between a history of childhood sexual abuse and eating disorders in women. In addition, the problems with the body of research and suggestions for further research will be discussed.

Studies of the CSA and Eating Disorder Connection

The following review of the research of the CSA and eating disorder connection is divided into those studies which used eating disorder patients as subjects and those studies which used non-eating disorder samples, including college students and therapy group members. The rates of women CSA survivors who have eating disorders in these two types of sample populations will be compared and methodological limitations of the studies will be discussed.

Eating Disorder Samples

Oppenheimer, Howells, Palmer and Chaloner (1985), in one of the earliest systematic studies of the sexual abuse and eating disorder link, studied the prevalence of childhood sexual abuse in seventy-eight female patients of an eating disorder outpatient clinic. All subjects were diagnosed with bulimia or anorexia nervosa, according to DSM-III (APA, 1980) criteria. Patients were asked to fill out a Sexual Life Events Questionnaire, which is a self report measure adapted from Finkelhor's survey (Finkelhor, 1979). The questionnaire asked about upsetting, coercive, and other coital and noncoital activity. Sexual events were defined as occurring before age thirteen by someone at least sixteen years old or between age thirteen and sixteen with the perpetrator being at least five years older and fit into one of ten very specific categories defining the type of sexual abuse. Questionnaires were administered by a female investigator. Some subjects refused to answer the questionnaire, thus it is likely that the reported rates of childhood sexual abuse were underestimated in this study.

Twenty-nine and one-half percent of the subjects reported childhood sexual abuse. However, an additional 34.6 % spontaneously disclosed other adverse sexual experiences outside of this study's definition. Thus 51.3 % of patients reported some history of sexual abuse in their childhoods. No evidence was found for a relationship

between childhood sexual abuse and the development of a particular type of eating disorder. Eighty-three percent of the perpetrators were well known to the subject and 36% were family members. The authors concluded that there are often important links of meaning to women surviving abuse between the abuse and later eating disorders.

Lacey (1990) interviewed 112 women who attended an eating disorder clinic. All of the subjects were diagnosed by Lacey as bulimic, according to DSM-III-R (APA, 1987) criteria. Seven percent of the sample reported a history of sexual abuse and 3.6% reported incest. The author stated he used a narrow definition of incest, yet believed he did not miss any cases of incest or sexual abuse. He concluded that the prevalence of incest among the majority of bulimics is far from high.

Palmer, Oppenheimer, Dignon, Chaloner and Howells (1990) investigated 158 women who were referred to an eating disorder clinic and met the DSM-III (APA, 1980) criteria for anorexia nervosa or bulimia (80 had anorexia and 78 had bulimia) concerning their recollections of sexual experiences with adults before age sixteen. Subjects completed the Sexual Life Events Inventory (SLEQ; Finkelhor, 1979), a self report questionnaire, and were interviewed about their responses to the questionnaire. Participants were asked about sexual experiences before age thirteen with someone over age sixteen, and from ages thirteen to fifteen

with someone who is five or more years older. Sexual experience was broken down into questions about different sexual activities. Age and socioeconomic status of subjects was also obtained. Thirty-one percent of subjects reported experiences within the criteria of childhood sexual abuse. The perpetrator was a male in all but two cases and known to the subject in 80% of the cases. The majority of events were experienced as distressing at the time of occurrence. There was no significant association between the type of eating disorder and the rate of abuse nor age category of abuse. In addition, there was no significant association between diagnosis and whether the sexual experience was intrafamilial or extrafamilial. This research can only raise the question about a relationship between CSA and subsequent eating disorders and that comparative data on other psychiatric samples and the general population need to be obtained.

Waller (1991) studied the link between child or adult sexual abuse, and anorexic or bulimic eating disorders. Sixty seven female patients who met the DSM-III-R (APA, 1987) criteria for anorexia nervosa or bulimia nervosa were divided into four subgroups: anorexia nervosa of the restricting subtype, anorexia nervosa of the bulimic subtype, bulimia nervosa with a history of anorexia, and bulimia nervosa with no history of anorexia. Two methods of assessment were used to see if it affected the reported

rates of abuse. One third of the subjects completed the SEQ (Calam & Slade, 1987) and all subjects were interviewed. Some women were interviewed about sexual abuse as a follow up to the SEQ while other subjects were asked in their initial clinical interview in the unit, which may affect the rate of reporting sexual abuse due to the comfortability level of women in these different scenarios. All subjects were asked by a male therapist, which may have impacted the level of disclosure. Waller (1991) noted that several women did not disclose sexual abuse during the initial interview, but did so later in therapy.

Forty-eight percent of the women disclosed sexual abuse in childhood or adulthood. No difference in rates of reporting was found between the interview and questionnaire method. The women diagnosed with bulimia with no history of anorexia had the highest rate of sexual abuse, while women with restrictive anorexia nervosa had the lowest rate of reported abuse. Twenty-seven percent of the sample reported unwanted intrafamilial sexual experiences. Waller (1991) hypothesized that unwanted sexual experiences did not predispose women to eating disorders per se, but that a history of sexual abuse determined the nature of any eating disorder that develops due to other factors.

Glenn Waller (1994) investigated how a secondary diagnosis of borderline personality disorder in 115 eating disordered women related to a history of childhood sexual

abuse. The subjects were attending an eating disorder clinic and met DSM-III-R (APA, 1987) criteria for anorexia nervosa or bulimia nervosa. All subjects were assessed for a history of unwanted sexual experiences using a version of Russell's (1983) interview and criteria for abuse. Fifty-one percent (59) of the women reported some abuse in childhood or adulthood. Of the fifty-nine women, 69.5 % were diagnosed as bulimic. The association between type of eating disorder and a history of abuse was significant. The women were also assessed for a secondary diagnosis of borderline personality disorder using DSM-III-R (APA, 1987) criteria. Thirty-nine percent of the fifty-nine eating disordered women with reported histories of sexual abuse met the criteria for borderline personality disorder. The women with borderline personality disorder reported initial abuse at an earlier age than women not given this diagnosis.

Waller (1994) concluded that this study confirmed that borderline personality disorder is associated with the reported sexual abuse and eating disorders. He proposed that a cluster of behaviors that led to the diagnosis of borderline personality disorder in women with eating disorders would be associated with sexual abuse at an earlier age. Childhood sexual abuse and associated factors may cause the child to use abnormal mechanisms of communication and emotional control, which manifest in the symptoms of both borderline personality disorder and the

eating disorder.

Hall, Tice, Beresford, Wooley and Hall (1989) studied 158 patients admitted to an eating disorder unit for the prevalence of sexual abuse. Ninety-eight percent of the sample was female. Data were obtained by clinical interviews and therapeutic interventions. Diagnosis for anorexia nervosa and bulimia were based on DSM-III-R criteria (APA, 1987). Comparative data of CSA incidence were obtained from adolescents on the treatment unit with diagnoses other than eating disorders. Abuse was divided into four categories: incest, fondling, rape and homosexual assault. Incest was defined as any form of sexual activity between a child and parent, step-parent, or extended family member while definitions for the other three categories were not given. In addition, the identity of the perpetrator, the type of sexual abuse behaviors, the age of onset of abuse and whether they were supported as a child if they disclosed the abuse was studied.

Fifty percent of the sample reported a history of sexual abuse, compared to 28% of nonanorexic and nonbulimic patients seen in this clinic. Eighty-five percent of these experiences occurred before age seventeen. Patients other than rape survivors had never shared their abuse history with anyone prior to this study's interview and would not share their abuse history until they gained trust in their therapist. Subjects were asked how they did not tell people

for so long about their CSA, especially if they were in therapy for years. Some subjects responded that they felt ashamed and were fearful of how other people, including family and friends, would view them. Through their interviews, the authors assessed that those subjects with a history of abuse who were bribed, made to feel special, or coerced into a conspiracy of silence were more likely to feel ashamed and concerned about their sexuality as adults. In addition, those subjects who were not believed when they reported the sexual abuse as a child were, according to these researchers, the most severely damaged later in life. When sexual abuse began early in childhood and was recurrent, many subjects were more likely to regard themselves as damaged goods and to feel unlovable.

Hall, Tice, Beresford, Wooley and Hall (1989) identified three eating patterns that they believed were related to subjects' history of sexual assault. One group of patients reported that their bulimia was triggered by anger toward male authority figures. A pattern in the anorexic group of patients was that patients would try to lose weight to the point of appearing skeletonized in an attempt to disgust their perpetrators. Anorexia, in these cases, seem to help these patients deny femininity, return to a safer time and break the emotional tie with the perpetrators. A third pattern was identified with patients who gained much weight following the abuse so that they

could become nonsexual. They found that once subjects revealed their sexual abuse history, a dramatic change occurred in the course of their treatment. The authors noted that several patients were able to make positive alterations in their eating patterns after they dealt with the sexual abuse. In cases where a sexual abuse history was disclosed, therapy directed to discussions of the consequences of the abuse was found to be helpful for the patients. Hall, Tice, Beresford, Wooley and Hall (1989) concluded that the data from this study strongly suggested that sexual abuse needs to be assessed when developing a treatment plan for eating disorders in women.

Palmer and Oppenheimer (1992) teamed up to investigate the prevalence of a history of sexual abuse in a group of 158 women with eating disorders versus a group of 115 women presenting with other psychiatric diagnoses. The eating disordered women were diagnosed as such according to the DSM-III (APA, 1980) criteria and all subjects were patients in a psychiatric unit. All subjects completed a self-report questionnaire and were interviewed by a female investigator. A sexual event was defined as one that was construed as sexual by the subject and occurred before age sixteen. The perpetrator was defined as a person who was age sixteen or over if the events occurred before the subject was twelve, or a person who was at least five years older if the subject was between thirteen and fifteen years old. Sexual events

were classified into four categories: sexual intercourse with penetration, other genital contact, nongenital contact, and events involving no contact.

Thirty-one percent of the eating disorder subjects reported fulfilling the criteria for sexual abuse compared to 49.6% of the non-eating disordered women with other psychiatric diagnoses. These results do not support a special association between childhood sexual abuse and increased risk of later eating disorders. Palmer and Oppenheimer (1992) speculated that a positive confounding variable may be that eating disordered subjects are more reluctant to disclose sexual abuse histories compared to women with other psychiatric disorders. They also noted that the eating disorder sample was younger than the psychiatric sample, which may have bearing on the level of disclosure of sexual abuse experiences. Though the authors did not find support for a link, they encourage routine inquiry about sexual abuse history to women presenting with eating disorders.

Folsom, Krahn, Nairn, Gold, Demitrack and Silk (1993) compared the rates of physical and sexual abuse in women with eating disorders and general psychiatric disorders. One hundred and two women with eating disorders and forty-nine women with general psychiatric diagnoses admitted to an eating disorder program and psychiatric unit under DSM-III-R (APA, 1987) criteria for their diagnoses completed the SLEQ

(Finkelhor, 1979), the EDI (Garner, Olmstead, & Polivy, 1983) and the SCL-90 (Derogatis, 1983). It was hypothesized that eating disordered women would report an overall higher incidence of physical and sexual abuse, as well as higher rates of more severe types of sexual abuse than would women with other psychiatric diagnoses. In addition, it was hypothesized that subjects who reported sexual abuse only, or both physical and sexual abuse would report more severe eating disordered symptoms and psychological disturbances than nonabused subjects both within and across sample groups. Sexual experiences were defined as abusive by the questionnaire when they occurred to subjects under age twelve and perpetrated by a person at least five years older, or when subjects were between the ages twelve and eighteen, the perpetrator was at least five years older, and after age twelve without consent of the subject, regardless of the age of the perpetrator.

Sixty-nine percent of women with eating disorders and 80% of women with general psychiatric diagnoses reported a history of sexual abuse, thus the rate of sexual abuse was not significantly different between groups. No association was found between a history of sexual abuse and the severity of eating disorder symptoms. The study did replicate previous studies' findings that female psychiatric patients report high rates of sexual abuse.

Calam and Slade (1987) examined the relationship

between eating problems and unwanted or intrafamilial sexual experiences in a sample of eating disorder patients and university undergraduates. Subjects were asked to complete a questionnaire which included the Eating Attitudes Test (EAT; Garner & Garfinkel, 1979) and the Sexual Events Questionnaire (SEQ; Russell, 1983). Calam and Slade (1987) found a significant association between eating problems and sexual experience. Of the 130 undergraduate females who completed questionnaires, 58% reported one or more unwanted sexual experiences. Thirty-one percent of respondents had one or more unwanted sexual experience before age 14 and 20% of respondents had one or more unwanted sexual experience within the family. Experiencing one or more sexual event was associated with higher scores on the EAT. In addition, both the use of force and younger age of unwanted sexual experiences correlated with higher scores on the EAT. However, the majority of women were at a sub-clinical level on the EAT. The comparison group, comprised of twelve women receiving treatment for eating problems, experienced even more unwanted sexual events before age fourteen, including more experiences of rape.

One interesting methodological technique in this study was that, in addition to the analyses conducted on the empirical data collected, the twelve comparison subjects were asked how they saw any possible links between their unwanted sexual experiences and their present eating

problems. Some of the subjects saw no links, whereas others identified control as being of major importance. These women felt out of control around the sexual abuse experiences and eating disorders gave them back some of that control. Some women also felt that the experience of abuse made them afraid to appear attractive to men and changed their body shape through disordered eating to avoid sexual advances from men.

Abramson and Lucido (1991) studied the relationship between childhood sexual experiences and bulimia. Female subjects were recruited from a university bulimic support group, inpatient eating disorder programs, private practices and university psychology classes. Sixty-three women completed the Bulimia Test (Smith & Thelan, 1984) and the SEQ (Finkelhor, 1979). Sixteen subjects were identified as bulimics with a mean age of thirty-four, while the nonbulimic group had a mean age of twenty-three. Sixty-nine percent of the bulimic group and 70 % of the nonbulimic group reported childhood sexual experiences. Bulimics did report significantly more sexual experiences with their fathers and brothers than did nonbulimics. The results suggest that the sexual experience in and of itself does not differentiate bulimics and nonbulimics, but the nature of the experience may influence the development of an eating disorder.

Steiger and Zanko (1990) compared the prevalence of

sexual abuse in eating disorder patients, psychiatric patients and normal women. Seventy-three women meeting DSM-III-R (APA, 1987) criteria for anorexia nervosa and bulimia, 21 female psychiatric patients, and 24 normal women, all within the same age range, completed, among other questionnaires, a brief self report questionnaire about their experiences of sexual trauma during childhood or adolescence. They also compared sexual abuse rates among eating disorder subtypes of anorexic restricters, anorexic bingers, bulimics with an anorexic history and bulimics with no prior anorexia, and differentiated between intrafamilial and extrafamilial sexual abuse. Sexual abuse history was reported by 30% of eating disordered women, with greatest prevalence (45.8%) being found in the subgroup of women who were categorized as bulimic with no history of anorexia. The rate of sexual abuse history in the normal control was unusually low (8.7%), while the rate of sexual abuse in the psychiatric control group (33%) fell in the range expected by Steiger and Zanko (1990). However, the sample sizes of the comparison groups were small. Steiger and Zanko (1990) noted that no simple association between sexual trauma and eating disorders as a whole was found. However, the criteria for assessing eating disorders was not uniform for all three groups, which could affect this study's results.

Steiger and Zanko (1990) looked at defense mechanism development as a possible intermediary link between sexual

abuse history and the development of an eating disorder. Incest survivors' scores on self-sacrificing defenses were more reliant than the other groups. The researchers proposed that the self-sacrificing position may lead people to neglect their own needs, which may contribute to the development of an eating disorder. Women with eating disorders who report incest, may rely more heavily on maladaptive psychological defenses, which may lead to the expression of affect through action.

In 1994, Welch and Fairburn conducted a case control study of the relationship between sexual abuse and subsequent development of bulimia nervosa, specifically. The investigators set out to determine whether sexual abuse increased the risk of developing bulimia nervosa, whether any increased risk was specific to bulimia nervosa or just any psychiatric disorder, and whether a clinical group of patients with bulimia nervosa differed from a community group in their histories of sexual abuse. Fifty women with bulimia nervosa were recruited from the community and matched with 100 women from the same community with no eating disorder to test the first research aim. The same bulimia nervosa sample was matched with 50 women with other psychiatric disorders to test the second research aim and finally, this bulimia nervosa community sample was matched with 50 women diagnosed with bulimia nervosa as patients in an eating disorder clinic to test the third research

hypothesis. The community group of women with eating disorders was obtained by surveying the caseloads of twelve general practices in England. The two surveys sent to potential subjects were designed to detect cases of eating disorders and cases of psychiatric disorders. Subjects whose surveys suggested bulimia nervosa were interviewed to establish this diagnosis. The interview was also designed to identify risk factors for bulimia nervosa and a history of sexual abuse.

The results of the investigation of the first aim of the study revealed that a history of sexual abuse was more common among the community subjects with bulimia nervosa than the normal comparison group. The result of aim two and three revealed no significant difference in the prevalence of sexual abuse with the community bulimia nervosa group and the general psychiatric comparison subjects nor the bulimia nervosa clinic patients. A history of sexual abuse was reported by a minority of subjects, indicating to Welch and Fairburn (1994) that sexual abuse is not a major risk factor for the development of bulimia nervosa. They stated that other etiological factors must operate in the majority of cases. However, when looking at the comparison of the community group of women with bulimia nervosa versus the normal community group, a history of sexual abuse was significantly more common among the community group of women with bulimia nervosa. The history of sexual abuse was just

as common for the community groups of women with bulimia nervosa and women with general psychiatric disorders. Thus, Welch and Fairburn (1994) concluded that sexual abuse history is not a specific risk factor for the development of bulimia nervosa, but a risk factor for psychiatric disorders in general for young adult women.

Welch and Fairburn (1994) seemed to make an effort to not continue to make the same mistakes of previous studies looking at the sexual abuse and eating disorder connection. Through out the article, they commented on problems in previous research studies and clearly explain their method, definitions and sampling process. They specifically stated that they designed this study to overcome some of the limitations of previous studies. The interview and criteria for inclusion in the bulimia nervosa group are clearly stated. In addition, the inclusion criteria for the comparison groups were clearly explained in the article. The definition of sexual abuse was clearly stated as any sexual experience involving physical contact that was against the subject's will. Only those experiences which occurred before the onset of bulimia nervosa were included.

Sloan and Leichner (1986) presented case studies of five of women on an in-patient unit for eating disorders who revealed histories of sexual abuse. The case material was obtained from hospital charts and personal interviews. Four of the five women attributed, at least in part, the

development of the eating disorder to their history of sexual abuse. Sloan and Leichner (1986) concluded that sexual abuse may have played a significant part in the etiology of eating disorders for many of their patients. "Once the factual nature of such material is entertained, certain aspects of anorexia nervosa cease to be as perplexing and can be seen as a rather logical outcome of early sexual trauma" (p. 659). They also concluded that, given not all sexually abused people develop eating disorders and not all eating disordered people have experienced sexual abuse, a sexual abuse history should be viewed as one of many psychological, biological and social factors operating in the development of eating disorders.

Non-Eating Disorder Samples

Finn, Hartman, Leon and Lawson (1986) studied women who were sexually abused for their increased prevalence of manifesting eating disorders. Eighty-seven women who were receiving group psychotherapy were individually interviewed to document the presence of sexual abuse history. Diagnoses of anorexia nervosa and bulimia were based on DSM-III (APA, 1980) criteria. Subjects were asked to complete a Sexual Abuse Screening Checklist and the Eating Patterns Questionnaire. The subjects who answered "yes" or "unsure" to any of the eleven items on the Sexual Abuse Questionnaire took part in a structured interview with a female

interviewer. The operational definition of sexual abuse included sexual contact with parents, stepparents, or grandparents; sexual contact with a treating physician or therapist and other sexual contact that was against the wishes of the subject. Sexual contact was defined to include only obvious sexual behavior, such as intercourse or fondling. There were no restrictions on the age at which the abuse occurred. Finn, Hartman, Leon and Lawson (1986) did not look at CSA separate from sexual abuse that may have happened after childhood.

Seventy percent of the subjects indicated some type of sexual abuse, while the remaining subjects who did not indicate sexual abuse within the authors' criteria acted as the control group. The sample was predominantly white, well-educated women. No subjects met criteria for current anorexia and 18.3 % of subjects met criteria for bulimia currently. Approximately 48 % of the subjects in both the sexually abused and control groups reported currently engaging in abnormal eating. Since Finn, Hartman, Leon and Lawson (1986) found no difference between the groups in the prevalence of eating disorders, they did not find support for the hypothesis that female therapy clients with a history of sexual abuse are especially likely to have histories of a significant eating disturbance. Finn, Hartman, Leon and Lawson (1986) speculated that clinicians may perceive an association between sexual abuse and eating

disorders because each condition is prevalent in so many women. Thus, they speculated that sexual abuse and eating disorders co-occur in many women with no meaningful connection. They did not comment, however, on the great difference in the number of subjects in their sexual abuse group (N=61) and the comparison group (N=26), which may have impacted the abnormal eating rate in the comparison group.

Calam and Slade (1989) examined the co-occurrence of sexual abuse and eating problems in a sample of 130 female undergraduate students. The EAT (Garner & Garfinkel, 1979) was used to measure to extent of problem eating and the SEQ (Russell, 1983) was used to indicate sexual experiences. It was hypothesized that the reporting of unwanted sexual experiences would be associated with higher EAT scores, and that dieting would be associated with reporting intrafamilial sexual experiences. Fifty-eight percent of the women reported some form of unwanted sexual experience, 31% before age 14. Twenty percent reported an intrafamilial sexual experience. The only form of sexual experience occurring before age 14 that correlated with a higher EAT score was sexual intercourse against the subject's wishes. Calam and Slade (1989) concluded that their study yielded a general pattern of co-occurrence of sexual experiences and scores for types of eating disorder symptomology higher than expected by chance. They suggested that sexual abuse should be seen as one of a range of possible triggers for the

development of an eating disorder. They also pointed out that their sample limits the generalizability of their results because these subjects have made it to college and people who experienced very severe abuse may not be able to function in such a setting.

Bailey and Gibbons (1989) studied the role of physical victimization in the development of bulimia. In addition, Bailey and Gibbons (1989) studied the effect that victimization has on the severity of bulimic symptoms. Questionnaires assessing the relationship between symptoms and victimization were completed by 294 female college students and 248 male college students. Anyone in the sample who was in therapy for an eating disorder was not included in the analyses of the relationship. They defined physical victimization as rape, sexual molestation, child abuse and partner abuse. They used the DSM-III (APA, 1980) criteria for bulimia to classify subjects on a continuum of exhibiting bulimic symptoms. Eight percent of the female sample were classified as bulimic. This study looked at race, age, and family income, among other demographic variables, and found no differences between bulimics and controls. The most common form of victimization reported among the female sample was sexual molestation (13%) and rape (11%). Twenty-eight percent of the female sample reported one or more type of victimization. No significant relationship between sexual molestation and bulimia was

found. There was a significant relationship, however, between child abuse and bulimia. Since a definition of child abuse was not given to subjects, it may be that some women who were sexually abused categorized themselves as experiencing child abuse instead of or in addition to experiencing sexual molestation. The researchers concluded that their study did not support the clinical impression of the relationship between victimization and bulimia, since only one of the four subtypes of victimization showed a significant relationship with bulimia. They also speculated that the often assumed causal relationship between sexual molestation and bulimia may really be a relationship of correlation. A history of sexual molestation among bulimics may not be a cause of the onset or severity of bulimia, but rather a reflection of how common sexual abuse is in the general population.

Smolak, Levine, and Sullins (1990) investigated child sexual experiences and family support as predictors of eating disorders in a sample of 298 females in college. In addition, the severity of the abuse and identity of perpetrator were studied for their possible effects on the development and severity of eating disorders. The sample, which was predominantly white and middle class, completed a child sexual abuse questionnaire and the Eating Disorders Inventory (EDI, Garner, Olmstead & Polivy, 1983). The sexual abuse questionnaire was created by Smolak, Levine and

Sullins (1990) for this study. It inquired about the nature and severity of the abuse and the subject's family during childhood. Subjects were asked if they had ever had a childhood sexual encounter by age thirteen with a person at least five years older than them or between ages thirteen and sixteen with a person at least ten years older than them. Smolak, Levine and Sullins (1990) stated that "sexual encounter" was defined for subjects, yet they did not share this definition with the reader. They did state that contact and noncontact were included and that most of their questions were based on Finkelhor's survey (1979). They also stated that the term "abuse" was not used in the questionnaire, which may effect subjects' interpretation of the questions. Subjects who reported some sexual abuse in childhood were asked further questions about their age at the time of the abuse, the sexual behaviors that occurred, the identity and age of the perpetrator, coercion, and the frequency and duration of experiences.

Twenty-three percent of the sample reported a history of childhood sexual abuse. Those subjects that reported a CSA history scored higher on the EDI. However, familiarity of abuser, severity of abuse and type of sexual contact were not related to the total EDI score. Smolak, Levine and Sullins (1990) concluded that there is no straightforward, simple relationship between childhood sexual abuse and eating disordered attitudes and behaviors. The influence of

parental reliability was studied and seen to have an effect on the outcome of childhood sexual abuse experiences.

Smolak, Levine and Sullins (1990) found that abused women who could not predict where their parents would be and when they would be there scored higher on the EDI than abused women with reliable parents. This may begin to shed light on the intermediary factors that possibly connect sexual abuse history and eating disorders in women. In fact, Smolak, Levine, and Sullins (1990) concluded that the path from child sexual abuse to an eating disorder involves a complex interplay of familial and personal factors. However, how this relationship among the sexual abuse, familial factors and eating disorder works is still unexplained.

Beckman and Burns (1990) studied the relation between the self-report of prior sexual abuse and the self-report of current eating behaviors consistent with bulimia. Three hundred and forty college women completed the Bulimia Test (Smith & Thelan, 1984) and a modified Life Events Questionnaire (Finkelhor, 1979). Subjects were asked about intrafamilial and extrafamilial abuse during different age periods and included abuse between same age children. Sexual experiences before twelve years of age involved events defined as sexual by the subjects. Sexual experiences after age twelve were defined as including an invitation to do something sexual through intercourse, which

was forced by a nonrelative or was forced or not forced by a relative. Eighty-nine percent of the sample was white.

Nearly 13 % of the women were classified as bulimic on the Bulimia Test and the remaining subjects made up the nonbulimic comparison group. The results of comparison showed that significantly more bulimic women (48.7 %) reported having had forced sexual experience after age 12 by a nonrelative than the comparison group (27.4 %). However, there was no significant difference between the two groups' report of intrafamilial or extrafamilial abuse before age twelve or intrafamilial abuse after age twelve.

Beckman and Burns (1990) concluded that this study only provided limited support of the hypothesis that bulimia is associated with prior experiences of sexual abuse. In addition, they suggested that the role of sexual abuse in the development of bulimia is a complex one.

Miller, McCluskey-Fawcett, and Irving (1993) investigated the possible relationship between childhood sexual abuse and the adolescent onset of bulimia nervosa in women. Seventy-two women identified on the Bulimia Investigatory Test, Edinburgh (BITE; Henderson & Freeman, 1987) as having a high probability of suffering from bulimia nervosa were matched with 72 women who did not display bulimic symptoms. The subjects, all from university classes, were matched on height, weight, age, marital status, and ethnicity. Most subjects were 18 and 19 years

old. Both groups were administered the BITE and SLEQ (Finkelhor, 1979) by female research assistants, among other questionnaires.

Sexual abuse was defined as a sexual experience before age twelve with an adult, a sexual experience after age twelve with a relative and a non-consensual sexual experience after age twelve. Fifteen percent of the bulimic sample and 1% of the nonbulimic sample reported sexual experiences with a relative after age twelve, which was a significant difference between the groups. It was also found that bulimics who were sexually abused dissociate more often than both bulimics who were not abused and by nonbulimics. Miller, McCluskey-Fawcett, and Irving (1993) speculated that the dissociation is an attempt to distance from the fear and helplessness a subject experienced during the abuse and that the binge - purge cycles may serve to provide a form of emotional numbing and psychological dissociation.

Hastings and Kern (1994) used restricted definitions of sexual abuse and bulimia to examine the relationship between bulimia, sexual abuse and a chaotic family environment in female college students. They criticized past studies of the relationship between childhood sexual abuse and bulimia for their weak empirical support of an association. In this study, 786 female college students of an average age of 22 and 80% of which are white, were divided into three groups

based on their BULIT-R (Thelan et al., 1991) scores. The subjects also completed the Child Sexual Abuse Questionnaire (Smolak, et al., 1990) and the Family Environment Scale (FES; Moos & Moos, 1984). Sexual abuse was defined as a sexual encounter when the subject was less than thirteen years old and the other person was at least five years older, and when the subject was between thirteen and sixteen years old and the other person was at least ten years older.

This study found that bulimia was strongly associated with self reports of sexual abuse. Forty-three percent of the bulimic sample compared to 6% of the normal group were classified as abused. Among abused women, the severity of the abuse was also related to the severity of the bulimia. The results of the FES showed that substantially more bulimic women (67%) than normals (36%) characterized their families as chaotic and conflictual. Hastings and Kern (1994) did further analysis to investigate whether family environment moderated a CSA - bulimia relationship and found that the chaos/conflict level of the family appeared to moderate the CSA - bulimia relationship. The results also indicated that the CSA and family variables combined in an additive manner to increase the risk of bulimia. The severity and traumatization of the abuse was also looked at and no significant relationships were found between bulimia and the familiarity of perpetrator or the type of abuse.

Hastings and Kern (1994) stated that the findings of

this study provided clearer support for the CSA - Bulimia link than prior controlled studies. It seems that in 1994, the researchers on this topic began to look at the weaknesses of past studies and went to great lengths to conduct more solid research, keeping in mind the past mistakes. Hastings and Kern (1994) wrote at length about the weaknesses of the past research and how they planned, in this study, to improve the research on sexual abuse and eating disorders.

Summary of Results

The incidence of women with histories of CSA and eating disorders varies according to sample populations. Of the thirteen studies that used women with eating disorders as their sample population, nine found support for the CSA-eating disorder connection. In the studies that gave support to the CSA - eating disorder connection, the rates of women with eating disorders who also had experienced sexual abuse ranged from 31 % to 69 %. The rates of CSA experiences in subjects with psychiatric diagnoses other than eating disorders varied from 28 % to 80%. Five of the seven studies that used non-eating disorder samples to investigate the CSA and eating disorder connection also found support for the connection. The incidence of college student women with eating disordered behavior who also had histories of CSA varied from 15 % to 49 %.

Generally, those studies using eating disorder samples found a higher incidence of women with both disturbed eating and experiences of childhood sexual abuse. This result may be due to the fact that four of the five non-eating disorder populations were college samples. Women who have sought treatment for eating disorders may be more likely to have grown up in certain types of family systems, such as enmeshed or strained family systems, than women attending college. The same family systems that may influence the development of an eating disorder may also predispose these women to sexual abuse. Thus, the college samples may have come from different family systems than the eating disorder samples, which could explain the higher incidence of sexual abuse in the eating disorder samples.

None of the studies that found support for a CSA and eating disorder connection found evidence of a direct relationship between CSA and eating disorders. The relationship between CSA and eating disorders is a complex one. Many researchers speculated about other factors that people experience that may influence a person's development of an eating disorder. For example, Waller (1994) hypothesized that a borderline personality disorder diagnosis in eating disorder patients may be associated with CSA. Miller, McCluskey-Fawcett and Irving (1993) speculated that dissociation may be a factor interacting in the CSA and eating disorder relationship. Hastings and Kern (1994)

hypothesized that the CSA and eating disorder connection may be moderated by a chaotic family. Abramson and Lucido (1991) speculated that the nature of the CSA, rather than the CSA in and of itself may influence the development of an eating disorder. As the research on the CSA and eating disorder relationship progresses, the focus seems to be shifting from a general and simple connection to discovering those factors that may mediate the complex relationship between CSA and eating disorders. It is only in the past few years that studies have looked at how the different types of eating disorders may uniquely relate to prior CSA.

Limits of Research

The findings of the twenty studies reviewed in this chapter must be interpreted with caution because there are methodological inconsistencies in terms of their samples, definitions, and inclusion criteria. The samples in this body of research are often not random because they often consist of people admitted to hospital inpatient units, people attending eating disorder clinics, or students in undergraduate psychology classes. In some studies, participants were recruited from specific groups and not given a choice as to whether or not to answer questions because for example, data were taken from intake interviews. Many of the samples were composed of the people who, on

their own accord, sought help for their problem. These samples may not be representative of the majority of sexual abuse survivors or women with eating disorders. There are many women who never seek help for either sexual abuse issues or eating disorders and these populations have not yet been studied. In addition, sample populations need to be expanded to include more random sampling from the community at large, as well as samples of sexual abuse survivors. The research could be strengthened by adding more non-clinical samples to studies, as well as including a wider diversity of subjects according to race, education level, sexual orientation, ethnicity, and socioeconomic status. These limitations of the samples weaken the external validity of the results from these studies.

The gender of subjects was not always consistent across studies. When samples are mixed in gender, the investigators did not always analyze results according to genders so that conclusions could be drawn for women's and men's incidence rates of CSA experiences and eating disorders. In addition, these studies cannot easily be compared to other studies that have all female samples. Many studies lacked comparison groups, which would allow for better interpretation of the findings about the CSA and eating disorder connection. Even if there was a control group in a study, one cannot be sure that the women in the "non-abused" group were a true comparison group due to the

common phenomenon of repression and reluctance to disclose sexual abuse histories.

The definitions and criteria used in the twenty studies varied greatly, making it difficult to compare the outcomes of the studies. Almost every study had unique inclusion criteria for sexual abuse experiences. For example, Oppenheimer, Howells, Palmer and Chaloner (1985) only included sexual experiences before age sixteen, whereas Finn, Hartman, Leon, and Lawson (1986) put no age criterion on sexual abuse experiences. In addition, the sexual activities included in the definitions of sexual abuse varies from study to study. Results are difficult to compare because the sexual abuse phenomenon measured is in each study is not the same.

The type of eating disorder or degree of disturbed eating also varied with each study. Abramson and Lucido (1991) only investigated bulimia's relationship to CSA, whereas Waller (1991; 1994) included anorexia nervosa and bulimia in his investigations of the eating disorder and CSA connection. In addition, some studies used DSM-III (APA, 1980) and DSM-III-R (APA, 1987) criteria to diagnose an eating disorder, whereas other investigators, such as Calam and Slade (1989), used questionnaires to categorize subjects' level of disordered eating. The degree of disturbed eating and the nature of sexual abuse experiences varied among studies because definitions, criteria and

measuring tools for eating disorders and CSA varied among studies. Again, it becomes unclear if these twenty studies are actually studying the same phenomena when their operational definitions are not the same.

Another methodological weakness of these studies is that many studies used male therapists and interviewers to collect data on the occurrence of CSA. The level of abuse may be underestimated in many studies due to the comfortability levels of women disclosing sexual abuse to a person of the opposite sex and to a person they have only recently met. The rates will likely be deflated due to a lack of trust between subjects and interviewer. In addition, interviewer or clinician bias may influence eating disorder diagnoses or the categorization of subjects into the sexual abuse survivors group. If the investigator herself or himself was assessing the subjects for eating disorders and CSA experiences, she or he may have had a belief about the connection before assessing the women, and then biased her or his assessments to reinforce her or his belief.

After nearly ten years of investigating the relationship between childhood sexual abuse and eating disorders, it seems that, recently, investigators have attempted to correct the methodological weaknesses of earlier studies and look at the complexity of the CSA and eating disorder relationship. There seems to be more of a

conscious attempt to be more careful about the quality and consistency of the research on the possible link between childhood sexual abuse and eating disorders. For example, in 1994, Welch and Fairburn used a great deal of text to critique past research on this subject and show that they were making every effort to conduct cleaner research that could be replicated. It seems that this body of literature is beginning to take shape and find direction so as to develop sound theories of the CSA - eating disorder connection in women.

Suggestions for Further Research

Future research on the CSA and eating disorder link can build on the existing literature and continue to look for possible causal links between childhood sexual abuse and eating disorders. Research should continue to focus on specific factors involved in the relationship between CSA and eating disorders. In addition, further research needs to learn from the methodological weaknesses of past research.

Future studies need to continue to investigate women with different types of eating disorders (bulimia, anorexia nervosa, and compulsive overeating) and their relationships to CSA so as to clarify the specific eating behaviors and patterns related to CSA. In the same way, research needs to include more sexual abuse survivors in the sample

populations so as to better understand their relationship with food and body image. Females and males of all ages should be included in future research so to better understand the pervasiveness of childhood sexual abuse experiences and disordered eating. Data collected on men and women should be kept very distinct so that nature of the CSA and eating disorder relationship for each gender can be understood more clearly. The strength of the findings of CSA and eating disorder research would likely increase if studies using non-clinical samples replicated the results of studies which used eating disorder samples or psychiatric patient samples.

Research should focus on mediating factors between CSA and the development of eating disorders, such as family cohesiveness or the presence of other psychiatric disorders. Also, teasing out physical abuse from sexual abuse in future studies may help us better understand how specific traumas in childhood effect the development of various psychiatric disorders in adulthood. Physical abuse may lead to different long term effects in women or men and may or may not have a connection to the development of psychiatric disorders, including eating disorders.

Future research should also include longitudinal studies of CSA survivors so as to look at how they psychologically develop and cope over time. These longitudinal studies could also investigate the family

environment as a possible mediating variable between CSA and the development of an eating disorder. Longitudinal studies of an average sample of children, followed to adulthood, which include questions about CSA, eating disorders, family environment and other psychiatric disorders could shed some light on how and why some people develop eating disorders who are not abused and some people who are survivors of CSA do not develop eating disorders. This longitudinal study of average children can also shed light on how people with different experiences deal with developmental stages. Such a study could help psychologists discover how children who are abused versus those who are not differ in their coping mechanisms, self-esteem, and overall psychological development. Longitudinal studies may be better able to answer the question of how eating disorders, the situational factors of CSA, and the family system relate to or effect each other.

In all future research, researchers need to take more care to clearly define the phenomena they are studying and diversify their samples to include people of different races, cultures, education level, socioeconomic groups, ages, sexual orientations, and genders. A standard definition for childhood sexual abuse should be developed and used in many studies so that researchers can be more sure they are replicating studies which investigated the same sexual abuse phenomenon. Researchers need to be more

aware of the possible impact experimental effects, such as the gender of the interviewer or therapist, and the quality of the rapport developed between subjects and researchers, may have on the outcomes of the studies of the eating disorder and CSA connection. In addition, more studies asking the women who have eating disorders and who have survived CSA what the connection means to them can help bridge the gap between objective, empirical research and the actual experiences of women.

CHAPTER V

A MODEL OF THE SEXUAL ABUSE AND EATING DISORDER LINK

To what extent are the history of childhood sexual abuse and the presence of an eating disorder in a woman a coincidence and to what degree are these issues related? If there is a connection, what might cause this relationship to exist? Is there one link or are there many factors that, put together, could lead a woman to both experience sexual abuse and have an eating disorder? This chapter will explore possible links between CSA that occurs within the family and eating disorders. A model that looks at the relationship between these two issues will be presented to conceptualize how childhood sexual abuse within the family and eating disorders may be related for women. Finally, suggestions for the clinical treatment of women will be presented.

In 1982, Garfinkel and Garner suggested that eating disorders be looked at from a multidimensional perspective, considering the individual's psychological and biochemical factors as well as familial and sociocultural factors in predisposing, precipitating, and perpetuating eating disorders. Five years later, David Finkelhor (1987)

suggested that the impact that sexual abuse has on a person needs to be understood in relation to the child's life before the abuse. Root and Fallon (1988) described the eating disorder - CSA connection as a complicated problem that has individual, familial, and cultural contributions. Physically victimizing experiences may contribute to women's vulnerability to developing disordered eating as a way to cope with anger, powerlessness, and depression (Root & Fallon, 1988).

Over 90% of people with eating disorders and people who have been sexually abused are women (Finkelhor, 1979). Women with histories of sexual abuse and women with eating disorders share certain characteristics. Some of the common characteristics used to describe these women include sexual conflict, poor body image, self-hate, self-destructive tendencies, low self-esteem, depression, feeling of helplessness and powerlessness, poor interpersonal relationships, and substance abuse (Kutcher, 1988). Survivors of CSA and women with eating disorders often exhibit similarly distorted thinking, disturbed perceptions, and maladaptive coping (Root & Fallon, 1988). Both survivors of CSA and women with eating disorders often feel isolated, lonely, and helpless (Bruch, 1978, DeYoung, 1982).

The families of CSA survivors and eating disordered women often exhibit similar qualities. These families tend to have relationships that are strained or enmeshed, and are

overprotective and rigid (Fournier, 1987). In addition, some similar psychological and situational factors these families share include social isolation, exaggerated patriarchal values, rigid gender role definitions, and the parentification of daughters (Pizzolo, 1989).

Mediating Factors

The mechanisms linking CSA and eating disorder symptoms are not well understood. Some of the mediating factors proposed by researchers include the nature of the abuse, the characteristics of the CSA survivor's family, dissociative disorders, and personality disorders. Society influences individuals through many avenues, including the family. Biases and dysfunctions of the world may be passed onto children by those around them. Some research suggests that the family is the teacher of social expectations to children (Kutcher, 1988). In the family, society is acted out and learned by children (Pizzolo, 1989). Root, Fallon and Friedrich (1986) state that a bulimic's family mirrors the inequity of the power between men and women in society. Susie Orbach, in her book about eating and the body image of women, describes the family system as the system responsible for reproducing the societal expectations of women and is the system responsible for incorporating these social messages into a woman's developing sense of identity, competence, power and self-worth (Orbach, 1978). Many

researchers have suggested that patriarchal families are more likely to manifest symptoms of sexual abuse and eating disorders (Finkelhor, 1979, Herman, 1981, Minuchin, et al., 1978, Root, Fallon & Friedrich, 1986).

Often, in families, as in society, power among members is unequal. Therefore, the respect for children may be lost and healthy boundaries between parent and child may not be respected. Ultimately, no one may be caring for the child's needs and the child may feel trapped. Children need to cope somehow and, as victims, they do whatever they can to cope, no matter how dysfunctional that coping may be. Since victimization is beyond their control, CSA survivors may "choose" an eating disorder as a means of coping. A woman who has experienced CSA may use an eating disorder to focus on controlling her appearance, as well as focus on bingeing and purging because it can be predictable and controllable (Root, Fallon & Friedrich, 1986).

The feelings stirred up in victims of CSA may come from the larger environment in which the abuse occurs, which includes the quality of care of the sexually abused female, as well as the level of psychopathology in her family. Thus, the long term effects of CSA may be caused by more than just the actual acts of CSA. Sexual abuse may be just one manifestation of invasive, dysfunctional, power relationships in families. Sexual abuse, particularly incestuous abuse, cannot be isolated from the context in

which it occurs (Connors & Morse, 1993). Therefore, when trying to understand the CSA and eating disorder connection, one must look at the context in which both the CSA occurs and the eating disorder develops. The family, personal relationships and societal influence are important contributors to the psychological well-being of the survivor of CSA and a woman with an eating disorder.

The cohesiveness of the family and how a trusted adult reacts to disclosure of the abuse may affect a female's chosen method of coping with the trauma. Poor family interaction and low self-esteem have been hypothesized as possible mediating factors between CSA and eating disorders (Waller, 1992). Finkelhor (1987) hypothesized that if a child, who comes from a very unstable family where loyalty of significant others is continually in doubt, is sexually abused, the betrayal of the CSA may be all the more serious because it is a compounding of a pre-existing dynamic. Smolak, Levine and Sullins (1990) found evidence for parental reliability affecting the outcome of the sexual abuse experience. Survivors of CSA may come from families with relationships that are less cohesive and adaptable or even conflict ridden (Mullen, et al., 1993). Root and Fallon (1989) also have suggested that many bulimics, in particular, are raised in unpredictable families and that the eating disorder is a way to gain a predictable control in a chaotic world. Family systems that manifest symptoms

of sexual abuse and eating disorders may not allow children to develop a sense of power and effectiveness (Kutcher, 1988).

Is the family the cause of both CSA and eating disorders in some women? Felitti (1991) posed this question about the long term effects many survivors present. Is the sexual abuse during childhood the primary destructive force or is it a marker for a severely dysfunctional family, which is itself the primary destructive force (Felitti, 1991)? Sexual abuse is suggested by some researchers as merely one element in a multiplicity of adverse social, family and interpersonal factors that may lead to the development of a psychiatric disorder such as an eating disorder (Mullen, et al., 1993). CSA may be so intimately tied up with a disrupted family environment that it may have very little validity when studied in isolation (Mullen, et al., 1993).

Some researchers have speculated that dissociation may be a mediating factor between the experience of CSA and the development of an eating disorder, specifically bulimia. Miller, McCluskey-Fawcett, and Irving (1993) found that bulimics who were sexually abused dissociated more often than bulimics who were not sexually abused and more than nonbulimics. They hypothesized that the dissociation is an attempt to distance from the fear and helplessness women experienced during the abuse. The binge - purge cycle of bulimia may be one way that CSA survivors attempt to

experience emotional numbing and psychological dissociation (Miller, et al., 1993). Root and Fallon (1989) concur with this idea that sexual abuse victims who have not worked through their emotional trauma may try to find ways to dissociate from these experiences. Binging and purging enables a bulimic to repress and dissociate from feelings of traumatic memories. They hypothesized that the individual focuses exclusively on food, weight, eating, vomiting and subsequent feelings of self-hatred, disgust and relief that following the purge experience (Root & Fallon, 1989). This focus allows an individual to escape from dealing with present or past abusive experiences and redirects her feelings about her victimization toward herself and her bulimia. They proposed that bulimia is an attempt to establish psychological and physical space (Root & Fallon, 1989).

Some studies have pointed to personality disorders as a mediating condition between CSA and eating disorders (Connors & Morse, 1993; McClelland, Mynors-Wallis, Fahy, & Treasure, 1991; Waller, 1993). Sexual abuse may influence personality development which, may in turn, may influence behaviors used in eating disorders (Waller, 1993). The comorbidity of eating disorders and other concurrent psychiatric disorders complicates any attempt to isolate the etiological factors of eating disorders, which makes it more difficult to isolate a possible CSA and eating disorder

relationship (Connors & Morse, 1993). This hypothesis is just one more avenue to explore in better understanding the relationship between CSA and eating disorders.

Model

Sexual abuse often leads survivors to feel powerless and out of control. One way a female survivor may deal with these feelings is to try to take control of her life through her food intake or her body. These females may develop an eating disorder. Many factors are likely involved with the development of any psychological condition or coping mechanism after experiencing CSA. Some studies have collected direct accounts from women with eating disorders and CSA about their situation. One survivor said that her weight problems were associated with her sexually intrusive father. Being fat was a way of insulating herself from men (Millman, 1980). Another woman reported that being fat was a desperate way to insist that attention be paid to what her father did to her. Her weight was an appeal for help and she wanted people to know how much she has suffered in her lifetime (Millman, 1980). Maltz and Holman (1987) hypothesized that the development of an eating disorder that results in extreme thinness or being overweight can be an unconscious reaction to incest and a way of avoiding acceptance of sexual maturity in young adulthood. Through her experiences treating female survivors of CSA who have

eating disorders, Anne Kearney-Cooke (1988) suggested that becoming a woman for a CSA survivor with bulimia means being powerless and out of control. Instead of criticizing a culture in which a high percentage of women are victimized, she criticizes her body, obsesses about it and sees it as her ticket to control. Her body is a safe battle ground to deal with anger and rage (Kearney-Cooke, 1988).

No model can adequately explain the complex interactions of factors that influence the sexual abuse experience, the development of an eating disorder and the link that may exist between these two phenomena. One can only begin to lay out the skeleton of the relationships that likely exist among many experiences and factors. Since the body of research on the relationship between CSA and eating disorders is so young, model presented in Figure 1 can bring better understanding to the relationship between CSA and eating disorders.

One possible model of the CSA - eating disorder connection includes societal, familial and individual factors. As seen in Figure 1, society may influence the family. The social influence and individual characteristics of the family may influence the likelihood that a child in such a family experiences sexual abuse. The same social and situational factors in the family may help determine how the child who is sexually abused copes with this trauma. If certain family dynamics and individual characteristics, such

as an enmeshed family or a personality disorder, are present, a child may develop an eating disorder as a way to try to cope.

In addition, a girl in a family with similar situational and psychological factors as the family in which CSA occurs could develop an eating disorder without being sexually abused. The presence in families of social messages about females, such as that their goodness is tied to looking a certain way and the presence of certain family factors, such as rigidity and isolation, may influence the likelihood of a girl being sexually abused and/or a girl developing an eating disorder. The families of the female CSA survivors who develop eating disorders may share some of the situational and psychological factors with the families of women and girls who were not sexually abused and develop eating disorders. The same family dysfunction that allows CSA to occur to girls may cause the development of eating disorders in women. In some cases, the experience of childhood sexual abuse may lead to eating disordered behavior in women.

Treatment Suggestions

The research on the potential CSA and eating disorder connection can give clinicians greater insight into women presenting with a history of childhood sexual abuse, an eating disorder, or both. This body of research should

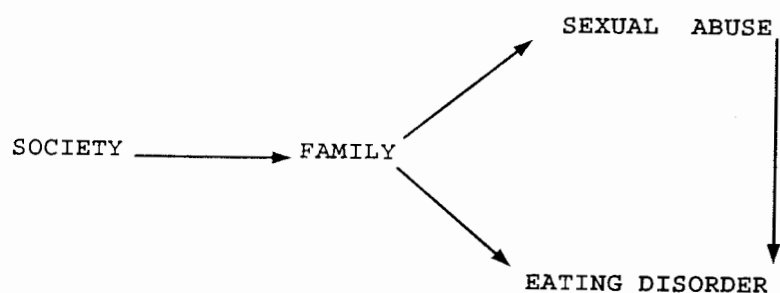


Fig. 1. A Model of the CSA and Eating Disorder Connection

influence clinicians to ask all survivors of CSA about their eating patterns and ask all women diagnosed with eating disorders about a history of CSA. One can only wonder if the recovery rates of eating disorders would be different if sexual abuse was asked about and dealt with in the eating disorder treatment.

This research may encourage medical and psychological clinicians to view their patients or clients in a more holistic way; taking into consideration that the mind, body, emotion, and environment (society and family) may affect their current state of being. Hopefully, the expanding body of research of the CSA - eating disorder connection will heightens clinicians' awareness of the connection of childhood trauma, and adult physical and psychological conditions. Clinicians should consider asking all patients or clients about childhood and adult traumas, eating behaviors and other psychiatric disorders as standard intake questions.

Conclusion

The relationship between childhood sexual abuse and eating disorders in women has been studied for over ten years. Though the studies have various flaws, the researchers have made a good start in better understanding how childhood sexual abuse and eating disorders in women potentially relate with each other. The body of research

has begun to focus on more specific links between these two complex phenomena. This review of the literature may serve as a resource for others who are trying to better understand how these two issues may relate. Ultimately, this body of research may help researchers and clinicians better understand some of the critical psychosocial issues facing women today.

APPENDIX A

SUMMARY OF THE RESEARCH ON THE CSA - EATING DISORDER CONNECTION

Author and Year	Sample	CSA Definition	Support of CSA-ED Link
Oppenheimer, et al., 1985	Eating disorder outpatient clinic (N=78)	Before age 13 by someone 16 or older; between 13 & 16 by someone 5 years older	Yes
Lacy, 1990	Eating disorder clinic (N=112)	Information not provided	No
Palmer, et al., 1990	Eating disorder clinic (N=158)	Before age 13 by someone over 16; between 13 & 15 with someone 5 years older	Yes
Waller, 1991	Eating disorder unit (N=67)	Information not provided	Yes
Waller, 1994	Eating disorder clinic (N=115)	Russell's (1983) criteria	Yes
Hall, et al., 1989	Eating disorder unit (N=158)	Any form of sexual activity between child & parent or extended family	Yes
Palmer & Oppenheimer, 1992	Psychiatric unit (N=115)	One that is construed as sexual by participant; occurred before 16	No

APPENDIX A - CONTINUED

Author and Year	Sample	CSA Definition	Support of CSA-ED Link
Folsom, et al., 1993	Eating disorder clinic (N=102)	Under age 12 by someone 5 years older; after age 12 without consent of participant	No
Calam & Slade, 1987	Eating disorder clinic & university undergraduates (N=142)	Russell's (1983) criteria	Yes
Abramson & Lucido, 1991	Bulimic support group, eating disorder unit, private practice, & university classes (N=63)	Information not provided	Yes
Steiger & Zanko, 1990	Psychiatric unit (N=118)	Information not provided	Yes
Welch & Fairburn, 1994	Community, eating disorder clinic, psychiatric unit (N=250)	Any sexual experience involving physical contact against subject's will	No
Sloan & Leichner, 1986	Eating disorder inpatient unit (N=5)	Information not provided	Yes

APPENDIX A - CONTINUED

Author and Year	Sample	CSA Definition	Support of CSA-ED Link
Finn, et al., 1986	Group psychotherapy (N=87)	Sexual contact with parents, grandparents, treating physician or therapist; other sexual contact against wishes	No
Calam & Slade, 1989	University students (N=130)	Russell's (1983) criteria	Yes
Bailey & Gibbons, 1989	College students (N=294)	Rape, sexual molestation, child abuse, & partner abuse	No
Smolak, et al., 1990	College students (N=298)	13 by someone 5 years older; between 13 & 16 by someone 10 years older	Yes
Beckman & Burns, 1990	College students (N=340)	Before age 12 & defined as sexual by subject; after 12 that were forced by non- relative, or any event with relative	Yes
Miller, et al., 1993	University students (N=144)	Before age 12 with an adult; after 12 with relative or non-consensual experience	Yes
Hastings & Kern, 1994	College students (N=786)	Before age 13 by someone five years older; between 13 & 16 by someone at least ten years older	Yes

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The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

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